EXPLORING AND DESCRIBING NURSE MANAGERS' VIEWS ON THE UTILISATION OF AGENCY NURSES IN DISTRICT HOSPITALS IN THE CAPE METROPOLE

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DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Date: March 2020

ABSTRACT

Background

Nursing worldwide is regarded as a scarce health human resource and there is literary evidence of an ongoing global nursing shortage. It is essential that nurse managers provide adequate staffing in hospitals. However, this often creates complex dilemmas, because nurse managers rely on agency nurses to amplify the permanent nursing staff due to the shortage.

Although agency nursing has become an important strategy to manage the nursing shortage, it brings along associated challenges of quality of care rendered and reported unacceptable conduct. It is for these reasons that the views of Nurse Managers are significant, because it may provide valuable insight and direction to address the issues of quality of care, ethics and nursing standards, including contributing to the national strategy to improve the monitoring of agency nurses.

Methods

A qualitative descriptive design was used for this study. A pilot interview was conducted to test the data-gathering instrument for possible errors, to clarify ambiguous questions, and to ensure a common interpretation of the terms used in the data-gathering instrument. No changes were made to the instrument. Data was collected from 14 participants in four focus groups, a face-to-face interview, and a telephonic interview, using semi-structured interview schedules. The interviews were recorded and transcribed verbatim. Thematic data analysis, using the Framework Approach, was guided by the research objectives. Atlas ti. computer software and manual data analysis were done to identify common themes. Ten common themes emerged from the data.

Results

The literature indicates that NMs in many countries around the world utilise agency nurses and they experience similar advantages with the utilisation of agency nurses, albeit in varying degrees. The findings further revealed similar common practices for sourcing, deployment and supervision of agency nurses in district hospitals.

Other findings were that hospitals have adequate structures and mechanisms in place to monitor and manage agency expenditure. There was also evidence that agency nurses provide quality nursing care.

Unanticipated findings include examples of unacceptable conduct of some agencies and agency nurses, the display of caring attitudes towards agency nurses, and nurses from other provinces with different standards, who do agency work in the Western Cape Province. The challenges reported by participants indicated the need for a monitoring system for the agency nursing industry.

Conclusion

Agency nurses make a valuable contribution in assisting hospitals to deliver patient-centred quality care. The dilemmas faced with the utilisation of agency nurses will need further investigation and the development and implementation of policy to regulate the industry.

Key words: Views, nurse managers, utilisation, temporary, agency nursing, district hospitals.

OPSOMMING

Agtergrond

Verpleging word wereldwyd beskou as 'n skaars gesondheids menslike hulpbron en die literatuur toon 'n voortslepende verplegingstekort wereldwyd. Dit is noodsaaklik dat verpleegbestuurders voldoende personeel in hospitale verseker. Soms veroorsaak dit egter komplekse dilemmas, omdat verpleegbestuurders aangewese is op agentskapsverpleegkundiges om die permanente verpleegpersoneel aan te vul as gevolg van die tekort.

Alhoewel agentskapsverpleging 'n belangrike strategie geword het om die verpleegtekort te bestuur, bring dit verwante uitdagings wat verband hou met die gehalte van sorg wat gelewer word en onaanvaarbare gedrag word ook ervaar. Om hierdie redes is die siening van verpleegbestuurders van belang, want dit kan waardevolle insig voorsien, en rigting aandui om die kwessies van gehaltesorg, etiek en verpleegstandaarde, insluitende 'n bydrae tot die nasionale strategie om verbeterde monitering van agentskapsverpleegkundiges.

Metode

'n Kwalitatiewe ondersoekende studie met 'n filosofiese ontwerp is onderneem. 'n Loods-onderhoud is gevoer om die dataversamelingsinstrument te toets vir moontlike foute, om dubbelsinnig vrae uit te klaar en ook om te verseker dat daar 'n gemeenskaplike vertolking van die terme in die dataversamelingsinstrument is. Geen aanpassings is aan die instrument aangebring nie.

Data is versamel van 14 deelnemers in vier fokus groepe, 'n persoonlike onderhoud en 'n telefoon-onderhoud deur die gebruik van semi-gestruktureerde vraelyste. Die onderhoude is opgeneem en verbatim oorgeskryf. Tematiese data analise het geskied by wyse van die Raamwerkbenadering en is gelei deur die studie doelwitte. Data analise is gedoen met die gebruik van Atlas ti. rekenaar sagteware, asook met die hand, om gemeenskaplike temas te identifiseer.

Resultate

Studie bevindings dui daarop dat verpleegbestuurders in baie lande agentskapverpleegkundiges benut, en hulle ervaar soortgelyke voordele met die gebruik van agentskapverpleegkundiges, alhoewel dit in aard verskil.

Verdere bevindinge van hierdie studie dui op soortgelyke gesamentlike praktyke vir die inkoop, uitplasing en toesighouding van agentskapverpleegkundiges in distrikhospitale. Ander bevindinge was dat hospitale voldoende strukture en meganismes in plek het om agentskapspandering te monitor en te bestuur. Daar is ook bewyse dat agentskapverpleegkundiges gehalte verpleegsorg lewer.

Onverwagte bevindinge sluit voorbeelde in van onaanvaarbare gedrag van sommige agentskappe en agentskapverpleegkundiges, 'n gesindheid van omgee vir agentskapverpleegkundiges, asook agentskapverpleegkundiges, met verskillende standaards, wie vanaf ander provinsies in die Wes-Kaap agentskapswerk doen. Uitdagings wat die deelnemers gerapporteer het gedui op 'n behoefte vir 'n stelsel om die agenstskapindustrie te monitor.

Slotsom

Agentskapsverpleegkundiges lewer 'n waardevolle bydrae tot hospitale in die lewering van pasiënt-gesentreerde gehaltesorg. Die dilemmas wat gepaard gaan met die gebruik van agentskapsverpleegkundiges moet verder ondersoek word, en die ontwikkeling en implementering van beleid moet geskied om die industrie te reguleer.

Sleutelwoorde: Siening, verpleegbestuurders, gebruik, tydelik, agentskapsverpleging, distrikshospitale.

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APPENDICES

LIST OF TABLES

ABBREVIATIONS

AHASA	Allied Healthcare Association of South Africa
ANASA	Association of Nursing Agencies of South Africa
ASD	Area Manager Nursing
CAPES	Confederation of Associations in the Private Employment Sector
CCN	Critical care nurse
CDC	Community Day Centre
DHS	District Health Service
DNS	Directorate Nursing Services
ENA	Enrolled nurse auxiliary
EN	Enrolled nurse
HREC	Health Ethics Research Committee
KRA	Key Result Area
ICN	International Council of Nurses
MDHS	Metro District Health Service
NCS	National Core Standards
NHS	National Health System
NIMS	Nursing Information Management System
NMs	Nurse Managers
PASA	Purchasing and Supply Chain Agency
PN	Professional Nurse
PVCM	Porter's Value Chain Model
RDHS	Rural District Health Services
SA	South Africa
SANC	South African Nursing Council
UK	United Kingdom
USA	United States of America
WCGH	Western Cape Government: Health

CHAPTER 1
FOUNDATION OF THE STUDY

1.1 INTRODUCTION AND RATIONALE

Nursing worldwide is regarded as a scarce health human resource and there is literary evidence of an ongoing global nursing shortage (Aiken, 2008:74; Kinfu, Dal Poz, Mercer & Evans, 2009:225; Morell, Kiem, Millsteed & Pollice, 2014:1; Rispel, Blaauw, Chirwa & De Wet, 2014:1;). The Western Cape Department of Health reports a shortage of 3768 nurses in 2016 (Western Cape Government, 2016:2). This nursing shortage, consequently, caused health care institutions to utilise agency nurses.

The researcher is a practicing nursing manager who experienced certain challenges with the utilisation of agency nurses to support frequent inadequate staffing numbers. The challenges with using agency nurses include: a perceived lack of required competencies, litigations due to medico-legal hazards, increases in patient complaints, poor attitude, lack of commitment, and tired, burnt-out WCGH employees who also do agency work, because of agencies not regulating working hours (Western Cape Government: Health, 2016:8). This situation tends to cause serious concerns related to ethical and accountable nursing practice, since nursing managers must remain within their allocated budget, ensure staff productivity and, most of all, render quality nursing care while taking cognisance of ethical and medico-legal risks (Rispel, Blaauw, Chirwa & De Wet, 2014:7; Toren & Wagner, 2010: 394-395).

The current practice in Western Cape Government: Health (WCGH) district hospitals to source agency nurses is as follows: (i) With input from the night Nurse Managers (NM's), the NMs on day duty identify the nursing skills needed in their wards on a daily basis, (ii) they apply internal hospital measures to reallocate on-duty nurses, (iii) they communicate their needs to procure additional skills to the senior NM for approval, (v) and then the senior NMs clerk sources the required skills via the Nursing Information Management System (NIMS).
NIMS is an electronic procurement and nursing information system that communicates the nursing skills needed to all nursing agencies approved by the WCGH.

NIMS is an electronic procurement and nursing information system that communicates the nursing skills needed to all nursing agencies approved by the WCGH.

Flexible working arrangements have become an acceptable, important strategy to manage nursing shortages and to address demand fluctuations in health facilities (Rispel & Moorman, 2015:1; Sukyong & Spetz, 2013:226). In South Africa, the procurement of agency nurses tends to be more affordable than overtime payment, since agency remuneration is based on a fixed rate while overtime payment is calculated according to permanent staff's individual salary level and package, which tend to be costlier.

However, although the utilisation of agency nurses saves on fixed-, recruitment and other costs in the short term it does not automatically mean that it is cost-effective (Sukyong & Spetz, 2013:226). During the 2009/10 financial year, R1.49 billion was spent on nursing agencies in the SA public health sector, which would have been sufficient for employing 5369 professional nurses (Rispel & Angelides, 2014:1).

Furthermore, the direct and indirect costs of utilising agency nurses suggest that quality of patient care may be compromised. This view is supported by literature (Rispel, Blaauw, Chirwa & De Wet, 2014:6; Rispel & Moorman, 2015:2, 5, 7; WCGH, 2016:8).

1.2 SIGNIFICANCE OF THE PROBLEM

It is essential that nurse managers provide adequate staffing in hospitals. However, this often creates complex dilemmas, because they have to rely on agency nurses to increase the capacity of the permanent hospital nursing workforce due to the general nursing shortage (Jooste & Prinsloo, 2013:1). The district hospitals included in this study utilise different categories of agency nurses daily (WCGH, 2016:1).

This statement concurs with Xue, Smith, Freund and Aiken (2012:2510) who state that the use of agency registered nurses has become the norm in helping to alleviate nursing staff shortages. The extent of global nurse staffing shortages are briefly summarised in the following table.

Table 1.1 Global nurse staffing shortages (Buchan, Seccombe, Gershlick & Charlesworth, 2017:2; Juraschek, Zhang, Ranganathan & Lin, 2012:241).

Region or country	In/by the year	Shortfall estimate
England	2015	22 000
USA	2020	At least 300 000
Sub-Saharan Africa	2006	600 000
South Africa	2011	37 501

Given the above data, the daily utilisation of agency nurses has become an accepted human resource strategy for health care institutions. From the agency nurse's perspective, reasons for doing agency nursing and additional work, as opposed to permanent work, include financial rewards like a higher income, being paid weekly as opposed to monthly, control over shifts, and more flexible working arrangements (Becker, S., McCutcheon, H. & Hegney, D. 2010:47; McIlroy, Billenness, Carter & Kinsky, 2016:4; Rispel & Angelides, 2014:5).

Utilising agency nurses seem to be a reality of the day in nursing care settings in the management of health care services and was experienced by the researcher as a nurse manager. The researcher deemed it necessary to obtain the views of nursing and ward managers as well as their deputies to gain valuable insight and direction in the realities of utilising agency nurses. This is considered important in the process of nurse managers, nursing agencies and agency nurses addressing the issues of quality patient care, ethics and nursing standards towards the national strategy for improving the monitoring of agency nurses (Rispel, Blaauw, Chirwa & De Wet, 2014:1).

1.3 PROBLEM STATEMENT

A problem statement clearly describes the research problem and highlights inconsistencies in the related literature (Botma, Greeff, Mulaudzi & Wright, 2010:268). Given the general nursing shortage, nurse managers rely on agency nurses as a human resource strategy (Becker, McCutcheon & Hegney, 2010:46).

However, this strategy holds associated challenges, most notably insufficient care quality and unacceptable conduct, which the researcher has experienced at his own hospital of employment.

Limited documented research findings are available on nurse and ward manager views regarding agency nurses. Their views are important, because it may provide pointers towards directives and the formalization of on-the-ground management practices to manage such a group of human resources.

1.4 RESEARCH QUESTION

What are the views of nurse managers on the utilisation of agency nurses in augmenting nurse staffing at district hospitals?

1.5 RESEARCH AIM

To explore and describe the views of nurse managers regarding the utilisation of agency nurses in district hospitals.

1.6 RESEARCH OBJECTIVES

The objectives of the study are to explore and describe nurse managers' views on:

- Common practices pertaining to the utilisation of agency nurses
- How nurse managers deal with budgetary restrictions pertaining to agency nurses
- How nurse managers deal with the provision of quality nursing care when utilising agency nurses

1.7 CONCEPTUAL FRAMEWORK

A conceptual framework is a specific collection of ideas denoting the conceptual starting point of a study. It comprises *concepts (*non-tangible ideas) and *constructs* (a combination or a blend of concepts that represents and points to a certain meaning) that aim to explain and give meaning to a study (Du Plooy-Cilliers, Davis & Bezuidenhout, 2014:55, 108-109).

The WCGH Provincial Nursing Strategy: 2016-2030 (WCGH: 2016-2030:6-7) Nursing Clinical Governance and Leadership strategic priority was the starting point for this study. However, additional conceptual frameworks, which are better aligned and more applicable to this research, are also reviewed.

The model guiding this research, is Porter's Value Chain Model (PVCM). The model serves both as a quality improvement method and a tool, which is used to identify and rank activities for improvement (Horne, 2013:658). The model provides clear guidelines through specified primary- and secondary activities to assist in the process of identifying value-generating activities, as well as processes that do not add value or improve processes (McGee, 2014:1, 2; Horne, 2013:666). PVCM has been adapted and applied to this research to illustrate how value-adding activities may be identified and used to improve the supply chain processes of sourcing, placement, monitoring productivity, cost and processing of agency nurse payments {Horne, 2013:660).It will be described in depth in Chapter 3.

1.8 RESEARCH METHODOLOGY

1.8.1 Research design

A research design is the complete plan of the research project mapping out the process from conception to completion and involving the selection of the most suitable methods to solve the problem under investigation (Du Plooy-Cilliers, Davis & Bezuidenhout, 2014:93; Anderson & Poole, 2009:22). For the purpose of this study, a qualitative descriptive research design was used.

Qualitative research is defined as a structured way of describing the experiences of participants, and to understand whereby the researcher explores the meaning attach to it (Flick, 2009:16). Focus group interviews, face-to-face, and telephonic interviews were used to collect data, allowing information to be obtained through direct argument by means of interview questionnaires (Botma, Greeff, Mulaudzi & Wright, 2010:205).

1.8.2 Study setting

The study was conducted at eight district hospitals in the Cape Metropole of the Western Cape Province, South Africa, who utilise agency nurses daily.

The Allied Healthcare Association of South Africa (AHASA), the coordinating body for nursing agencies in South Africa, and the Directorate Nursing Services (DNS) of the Western Cape Government: Health (WCGH) were included in the study.

1.8.3 Population and sampling

A study population refers to all persons or events that meet the inclusion criteria of the study. In this case, the study population was eight district hospitals.

Through sampling, the study population must then be reduced to an accessible, distinctive group of the population available to contribute to a study (Botma, Greeff, Mulaudzi & Wright, 2010:124). The study sample consists of six hospitals randomly selected. The researcher used a stratified sample to purposively collect data from a heterogeneous group of participants to contribute to the richness of the data.

Every hospital has one nurse manager that assumes ultimate responsibility for nursing services. It is common practice that hospitals with more than one deputy nurse manager, the staffing portfolio is assigned to one of them - thus four deputy managers were included. District hospitals may have more than one medical and surgical ward, but these wards are managed by one ward manager. Therefore, one ward manager each from an adult medical and surgical ward was selected per hospital, totaling eight. NMs form the key focus of the study and to thus enhance credibility and coherence, participants who are in nurse manager, ward manager or deputy manager positions for at least two years were included as study participants. Two years were allowed to represent a relatively consolidated experience in the utilisation of agency nurses.

Apart from nurse managers, one representative each was also included from AHASA and the DNS, WCGH, who is responsible for nursing agencies.

1.8.4 Data collection

Data collection was conducted through four focus group interviews with the hospital participants comprising two Heads of Nursing Services (HoNS), seven deputies and three ward managers. This was complemented by a telephonic interview with an AHASA participant and a face-to-face interview with a DNS participant.

The researcher is a practicing nurse manager at a regional specialist hospital outside the Cape Metropole and has frequent contact with district hospital NMs, ward managers and nursing agencies, thus measures were taken to avoid variance of interest (Palaganas, Sanchez, Molintas & Caricativo, 2017:427). A facilitator was used to facilitate the group interviews to reduce potential bias by the researcher, because of his familiarity with the participants Semi-structured interview schedules, formulated around the research objectives, were used for data collection (Annexures 4), which were conducted at participants' places of employment. The possibility of influencing the involvement of participants from different hospitals at management different levels has been identified and a strategy was devised to observe, and manage group behaviour.

1.8.5 Pilot study

A pilot study is a procedure for testing the accuracy and reliability of a data gathering instrument on a small segment of the study population before commencing the actual research (Du Plooy-Cilliers, Davis & Bezuidenhout, 2014:257).

The pilot study was done at one of the eight district hospitals. The HoNS and her two deputies were used to test the focus group interview questionnaire for possible errors and to clarify ambiguous questions, ensuring that participants had a shared understanding of the terms used in the data-gathering instrument (Du Plooy-Cilliers, Davis & Bezuidenhout, 2014:257). The data was included in this study.

1.8.6 Rigour in qualitative research

Botma, Greeff, Mulaudzi and Wright (2010:292) cite Lincoln and Guba (1985:218) who state that rigour is established by subjecting a proposal to the following four criteria: *truth value or credibility, applicability, consistency and neutrality.*

Truth-value or credibility refers to the degree of precision with which the research findings are reported (Botma, Greeff, Mulaudzi & Wright, 2010:233, 292). An experienced facilitator was used that could support members to unpack their experiences and views and to collectively extract meaning from the discussion, was used. Research diaries were also kept by the researcher and facilitator. The researcher had access to the facilitator's diary.

Applicability is defined as the degree to which the study findings can be generalised to other studies (Botma, Greeff, Mulaudzi & Wright, 2010:233). It may be possible to generalise the findings of this study, to some extent, to other public general hospitals.

Consistency considers whether the findings will be constant if the study were to be reproduced with the same participants in a similar setting. This was achieved by keeping detailed records of data collection, analysis, an accurate description of the methodology (Botma, Greeff, Mulaudzi & Wright, 2010:233). These records were verified by the study supervisor and researcher.

Neutrality refers to the degree to which the findings of the research are free from bias, motives or perspectives (Botma, Greeff, Mulaudzi & Wright, 2010:233). Neutrality was achieved by keeping records of all data sources, data collection methods, experiences, assumptions, decisions made and meanings deduced. The influence of the researcher was carefully reflected upon, unpacked and accounted for during the preliminary analysis done with the supervisor.

1.8.7 Data analysis

Data analysis involves separating the data into manageable themes, trends, patterns and relationships in order to understand and interpret it.

The focus group discussions and interviews were audio taped and transcribed. The researcher conducted the data analysis, guided by the research objectives, using both Atlas.ti and manual analysis to identify common themes. The study supervisor was consulted throughout this process.

1.9 ETHICAL CONSIDERATIONS

The researcher obtained ethics approval from the Health Research Ethics Committee (HREC) (S18/08/174) at the Stellenbosch University and abided by the ethical requirements once the proposal was approved. Permission was also obtained from the WCGH. Written, informed consent was obtained from participants. Written information was also provided about the nature, purpose and process of the study. It included information on the voluntary nature of participation and a statement that data will only be used for the purposes of this study. Participants' identities would also be protected through the use of pseudonyms – providing some degree of anonymity.

Participants would not be harmed, and they could withdraw from the study at any time without any negative consequences. Access to the data was be restricted to the researcher, supervisor and the fieldworker, thus ensuring confidentiality and anonymity. The fieldworker had to hand in all field notes.

The data and field notes were to be stored electronically with password protection for at least five years at Stellenbosch University. Publication of the study findings would be done in a manner prescribed by the university and would also be communicated to all participants.

1.10 RISKS AND BENEFITS OF PARTICIPATION IN THE STUDY

This study posed minimal risk to participants Risk was reduced by requesting that the focus group discussions be kept private and confidential, thereby protecting the integrity of participants and the privacy of individual contributions.

Participants were informed in writing that there was no financial benefit derived from participation in this study. However, reimbursement for participant transport expenses were supplied for.

It was also explained that an in-depth understanding of the views through participation in the study may benefit participants because it could provide valuable insight and recommendations to support managers' efforts in improving the utilisation of agency nurses and the quality of nursing care in hospitals.

1.11 OPERATIONAL DEFINITIONS

- **Agency nurses**: Providers of paid nursing services through a nursing agency or nursing bank.
- **AHASA:** an acronym for the Allied Healthcare Association of South Africa, which is the coordinating body for SA nursing agencies.
- **Deputy** refers to the nominated deputy of the Head of Nursing Services.
- **District hospital** means a level one hospital owned and operated by the Western Cape Government, which provides health excluding psychiatric-, infectious diseases-, maternity hospitals and clinics.

- **Head of Nursing Services** (HoNS) refers to a professional nurse who assumes ultimate responsibility for nursing services in a hospital.
- **Temporary** means non-permanent or short-term use of services
- **Ward manager** refers to an Operational Manager who is officially designated as the nurse in charge of a general ward.
- **Utilisation** means the sourcing, deployment, supervision and financial management of agency nurses.

1.2 DURATION OF THE STUDY

Table 1.2: Timeline for the study.

Ethics approval (expected)	October 2018
Pilot study	July 2019
Data collection	July-August 2019
Data capturing, preliminary analysis and interpretation	August-September 2019
Write the formal research report and corrections	October-November 2019
Submission of thesis	9 December 2019

1.13 CHAPTER OUTLINE

- Chapter 1: Introduction and background to the study, problem statement, aim and objectives of the study and brief overview of the research methodology.
- Chapter 2: Literature review.
- Chapter 3: Research methodology.
- Chapter 4: Data analysis and interpretation.
- Chapter 5: Discussion, conclusion, recommendations and limitations.

1.14 BUDGET

The researcher funded the cost of the study as illustrated in Table 1.3.

Table 1.3: Budget for the study.

Item	Unit cost	No. of units	Total
Travel: Researcher	R3.40/km	492km	1672.80
2 semi-structured discussion guides 20 consent forms 2 manuscript books (field notes for researcher and facilitator)			8.00 17.00 36.00
Return travel cost of participants - one private vehicle from 1 venue	R3.40/km	Approx. 94km	320.00
Refreshments for participants	R25	12	300.00
Transcription of audio tapes	R90/hour	10 hours	1500.00
Data analysis	R2500/transcript	6 transcripts	15000.00
Language editing & formatting			5600.00
Printing and binding of thesis			750.00
TOTAL			**23 470.00**

1.15 SIGNIFICANCE OF THE STUDY

The findings of the study may benefit nurse managers, agencies and agency nurses because it could provide valuable insight and recommendations to support managers' efforts in improving the utilisation of agency nurses and quality nursing care in hospitals. It may also inform current WCGH directives and policy development processes.

1.16 CHAPTER SUMMARY

Chapter 1 gave a brief overview of the impact of the shortage of nurses in the public health sector and highlighted public hospitals' dependency on agency nurses to supplement full time hospital nursing staff numbers.

This chapter also mentions the challenges nursing managers face when making use of agency nurses, and highlights the need for developing guidelines for nursing managers when using agency nurses.

Current hiring practices in the utilisation of agency nurses bring benefits, but also unintended consequences. An in-depth understanding of the views of nurse managers and their deputies may support nursing managers' efforts to address current challenges in district hospitals in the Cape Metropole.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 1 describes the background, rationale and methodology for this study. The literature review presented in chapter 2 provides an overview by describing the various forms of agency work. This is followed by an overview of global and local contexts as well as health care managers' experiences and perceptions of the utilisation of agency nurses. It is expected that the findings of this study will provide valuable insight and direction in supporting the improvement of the utilisation of agency nurses, address issues of quality patient care, ethics and nursing standards, as well as contribute to the national strategy for improving the monitoring of agency nurses (Rispel, Blaauw, Chirwa & de Wet, 2014:1).

2.2 ELECTING AND REVIEWING THE LITERATURE

The literature review was initiated by doing electronic database searches over two search periods – incorporating CINAHL, EbscoHost, Medline, ScienceDirect, SUNScholar and Google Scholar databases, as well as the South African Nursing Council (SANC), the AHASA and the International Council of Nurses (ICN) websites for literature published from 2004-2018.

Key words used for the search include casual, temporary and part-time work, moonlighting, agency, agency nursing, staffing, nursing manager, protocols and guidelines. Other relevant literature perused include articles for the search received from the supervisor of this study, from two librarians and the literature as the study progressed.

2.3 GENERAL OVERVIEW OF AGENCY WORK

Various research studies have been done internationally on nurse staffing in general, and healthcare organisations' responses to nurse staffing shortages in particular (Aiken, 2008:73; Kinfu, Dal Poz, Mercer & Evans, 2009:225-230; Becker, McCutcheon & Hegney, 2008:46).

Nurses form an integral part of human health resources, and their contributions are essential for improved health quality (Rispel, 2008:5, 13; Jooste & Prinsloo, 2013:1). The review of international literature about agency nurses and nursing are included under the following headings:

- The nursing agency phenomenon
- Origins of agency nursing
- Reasons for employing agency nurses
- Reasons nurses undertake agency nursing work
- Value of utilising agency nurses
- Concerns regarding agency nurse staffing
- Policies guiding agency work.

2.3.1. THE AGENCY NURSING PHENOMENON

The agency nursing phenomenon occurs in many countries as is evident in literature from the United States of America (USA), Australia, the United Kingdom (UK), Sweden and South Africa (Sukyong & Spetz, 2013:216; Shacklock & Brunetto, 2012:36; Hurst & Smith, 2010:287; Rispel & Moolman, 2015:2; Jansson & Engstrom, 2016:4). It manifests in various forms, and is described in literature using a range of descriptors such as flexible, casual, temporary or per diem work arrangements, internal float pool or nursing bank, agency work, supplemental nursing and non-standard work.

Flexible, casual, temporary or per diem nurses are defined as (i) nurses working through an independent agency. This method of labour workforce supply allows nurses to work when they are available and according to the needs of a healthcare facility (Adams, Kaplow, Dominy & Stroud, 2015:1; Rispel & Blaauw, 2015:44; Rispel & Moolman, 2015:1). Furthermore, (ii) nurses who are in permanent employment, but also registered with an independent, outside agency which places them at healthcare facilities where they undertake extra work (Dall'Ora & Griffiths, 2017:1; Rispel & Moolman, 2015:2).

An *internal float pool or nursing bank* refers to nurses who are employees, are familiar with the policies, procedures and routines and make themselves available for extra work at their own places of employment (Adams, Kaplow, Dominy & Stroud, 2015:1, 2; Rispel & Moolman, 2015:2).

Agency nurses are defined as independent nursing service providers through a nursing agency (Jooste & Prinsloo, 2013:3). Agency or bank nursing can be a main job, a second job or a second source of temporary empoyment (Tailby, 2005:373). *Supplemental nurses* are described as nurses rendering short-term services via an independent agency (Xue, Smith, Freund & Aiken, 2012:2510). Another definition of agency work is referred to as *non-standard work*, i.e. casual, agency and part-time work (Becker, McCutcheon & Hegney, 2010:46). *Moonlighting* refers to taking up additional, paid work besides the primary, full-time job and may be worked within, or outside their primary, full-time job (Rispel, Blaauw, Chirwa & De Wet, 2014:3).

It is clear from the literature that the terms *agency nurses* and agency *nursing* have different interpretations and are applied in different ways. For the purpose of this study agency nurses are defined as nurses who provide paid nursing services through a nursing agency or nursing bank, whether in their own facility, or elsewhere.

2.3.2 ORIGINS

The origins of temporary (or agency) nursing dates back to the early 1860's when Florence Nightingale identified the need for temporary nurses to do night duty in response to a need in the military hospitals at the time (Helmstadter, 2004:590-621 according to Collier, 2011:13).

Today, nursing agencies exist as one of the means to make it possible for (i) nurses to work part-time, flexible hours, (ii) them to have more than one work opportunity and (ii) for healthcare facilities to make use of the flexibility and efficiency incentives it offers (Rispel, 2008:18; Sukyong & Spetz, 2013:216, 218, 225, 226; Becker, McCutcheon & Hegney:2010:46-49).

2.3.3 Reasons for employing agency nurses

Hospitals frequently have an increased demand for agency nurses, primarilly because of nurse shortages, increases in patient admissions as well as for productivity incentives, such as saving on the higher costs of paying overtime in favour of using less costly agency nurses (Sukyong & Spetz, 2013:217, 222, 224).

The efficiency losses for hospitals lie in the fact that a 100% full-time staffing model is costlier, because of the associated overhead costs, while the flexibility and lower cost in terms of not having to pay overhead costs associated with agency nurses are more cost effective (Peerson, Aitken, Manias, et. al., 2002:504; Becker, McCutcheon &

Hegney, 2010:46; Sukyong & Spetz, 2013:216). In addition, absence due to sickness among permanent employees is a major contributing factor to the use of agency nurses in the UK, where nursing is reported to have one of the highest sickness rates of all UK public services (Hurst & Smith, 2010:288). Hospitals fill the void caused by vacancies and absenteeism by utilising agency nurses to reduce patient waiting times and ensure that the desired nurse-patient ratios are met (Sukyong &Spetz, 2013:216).. Furthermore, availability of agency nurses helps hospitals to be flexible in getting staff when nurse managers have difficulty in getting their own staff to work overtime, work across units in the hospitals and to be on call (Sukyong & Spetz, 2013:218).

The reasons provided by the literature, indicate that the use of agency nurses fill the gaps caused by the shortage of nurses, vacancies and absenteeism and is therefore, an important human health resource to be managed carefully for maximising benefits to patients, hospitals and agency nurses themselves.

2.3.4 The reasons nurses undertake agency nursing work

In a UK study, the National Health Service (NHS) produced a research paper on the nature of, and reasons for, nurses choosing to do agency work.

The study sampled approximately 95 000 nursing placements in the UK's NHS and private sectors, and advances the following reasons from the agency nurses' perspective why nurses work through agencies: (i) wanting to decide where and when they want to work (flexibility), (ii) deciding on the length of shifts they select, (iii) compensation rates are higher than overtime rates, (iv) a better work-life balance, and (v) more direct patient care with less paperwork (McIlroy, Billnness, Carter & Kinsky, 2016:3, 4,15,17,20,21). The following quotation makes a valuable contribution to a better understanding of agency nursing in the UK:

> *"The very things nurses are seeking from agency work – control over shifts and hours, better work-life balance… will all have to become the norm for permanent NHS staff."*

The above quote seems to be in agreement with similar statements made by various authors regarding the utilisation of agency nurses as an accepted human resource strategy in health (Becker, McCutcheon & Hegney: 2010:45; Rispel & Moorman,

2012:1; Sukyong & Spetz, 2013:226). One limitation of the study is the low response rate: only 455 out of 10 000 participants responded, making the findings representative of this study only, and not applicable to all UK agency nurses (McIlroy, Billnness, Carter & Kinsky, 2016:12).

A South African study conducted by Rispel, Blaauw, Chirwa & De Wet (2014:5-7) states that 72.5% of nurses admitted that (i) more money was a factor and (ii) 81.1% agreed that the weekly agency payment was a motivating factor. Other reported reasons for doing moonlighting include: (iii) continuity of care (92.7%), (iv) opportunities to obtain new skills (87.8%) and build relationships with co-workers (84.4%) (Rispel, Blaauw, Chirwa & De Wet, 2014:5-7), (v) increased opportunities for personal development, (vi) it allows nurses to escape and avoid the stress associated with permanent employment, and (vii) being able to escape the politics of the clinical situation (Collier, 2011:19, 26, 55).

Thus, the literature seems to indicate that nurses value the freedom of choice to determine their conditions of employment including income, flexibility to select the place of work, length of shifts and create a work-life balance created on their own terms. Agency nursing, in its various forms, provide this freedom of choice.

2.3.5 Value of utilising agency nurses

Sukyong & Spetz (2013:216, 218, 225, 226) report the following benefits associated with the utilisation of agency nurses: (i) shorter waiting periods for patients during hospital admissions, (ii) meeting the desired nurse-patient staffing ratios, (iii) relative affordability in using agency nurses as opposed to the cost of full-time staff during unneeded hours of work, (iv) covering short-term staffing needs of a healthcare facility and saving on overhead costs of fulltime staff, like medical aid and leave benefits, and (v) agency nurses being more amenable to work inconvenient shifts, due to a higher hourly pay.

Becker, McCutcheon and Hegney (2010:46,48,49) further mention the following additional benefits associated with the utilisation of agency nurses: (i) The engagement of a greater percentage of "benefit-free casual staff" versus full-time only staff allowing for flexibility so that they can be used according to patient and workforce requirements, and (ii) casualisation offers more flexible opportunities for the mainly

female nursing workforce who wish to remain in the profession (Becker, McCutcheon & Hegney:2010:46-49).

Nursing worldwide is a scare human health resource and, therefore, variable work arrangements through the utilisation of agency nurses is an acceptable and valuable strategy for managing the current nursing shortage because of its associated benefits (Rispel, Blaauw, Chirwa & De Wet, 2014:1; Dal Poz, Mercer & Evans, 2009:225; Rispel & Moorman, 2012:1; Sukyong & Spetz, 2013:226).

2.3.6 Concerns with agency nurse staffing

Concerns related to the utilisation of agency nurses are commonly mentioned in literature and is briefly discussed here.

A Swedish study reports on critical care nurses' (CCN) experiences in working with, or as temporary agency staff. The study found that: (i) it is very draining to constantly meet new agency staff due to the increased utilisation of agency nurses and (ii) agency nurses do not participate in planning and development and are, therefore, not up to date with the ward routine and processes. Although this was a small-scale study based on interviews with five agencies and five full-time CCN's, it does provide a better understanding of the effects of the too frequent utilisation of agency nurses in hospital units (Jansson & Engstrom, 2016:6-8).

Thus, agency nurses may not have similar exposure to professional development opportunities as their counterparts who are in full-time employment. An Australian study conducted by Becker, McCutcheon and Hegney (2010:48) highlights the prospect of professional development of agency nurses as a key disadvantage, because they are not available in the wardslong enough for this to happen.

In its Provincial Nursing Strategy document, the South African WCGH (2016:8) recognises the following challenges regarding the utilisation of agency nurses: (i) a lack of required skills, (ii) increased claims due to medico-legal hazards, (iii) an increase in patient complaints, (iv) poor attitudes, (v) lack of devotion, and (vi) burn-out due to working unregulated working hours through agencies, because the majority of agency nurses are also employees of the WCGH.

The last challenge is supported by literature (Van der Colff & Rothmann, 2014 in Engelbrecht, Rau, Nel & Wilke, 2019:6). Emotional exhaustion and burnout are concerns when nurses moonlight or work overtime.

In a 2010 study conducted by Rispel & Blaauw, the consequences of agency nursing and moonlighting in the health system of SA are reported on. A cluster sample of 80 randomly selected public and private hospitals in four provinces was studied. These were from the Eastern Cape, Gauteng, Free State, and the Western Cape, comprising a balanced mix of rural and urban provinces. Participants completed a self-administered questionnaire that gathered information on agency nursing, moonlighting and any incidents experienced while on duty during the 12 months prior to the survey (Rispel & Blaauw, 2015:43-44). The study findings reveal that moonlighting occur very often (40.7%). Absenteeism amongst permanent employees assumed various forms, e.g. taking annual leave and sick leave to perform agency work and moonlighting (11.9% and 2.8% respectively) and, not surprisingly, the majority of participants (51.5%) reported feeling too tired to work when on duty (Rispel & Blaauw, 2015:44, 45, 53). The study findings thus confirm the negative perceptions about agency nurses.

Surprisingly, the differences about these phenomena between non-agency nurses and those doing agency nursing and moonlighting were not statistically significant. However, the authors state that healthcare managers have a valid reason to be concerned, because of the potentially serious consequences generally associated with the utilisation of agency nurses (Rispel & Blaauw, 2015: 50, 53).

A USA study investigated the association between agency nurses and nurse and patient safety outcomes. Their survey sample consisted of 4954 PNs in 277 medical and surgical units across 142 hospitals (Bae, Mark & Fried, 2010:333).
The study found that medical and surgical nursing units employing more than 15% of agency PNs had higher levels of nurse back injuries and patient falls (Bae, Mark & Fried, 2010:341).
However, the authors state that the total hours of care delivered by agency- versus permanent employees, rather than the category of staff (RN, EN and ENA) could be

the most significant factor related to patient falls (Bae, Mark & Fried, 2010:342). The researcher could not find other literature that supports this interpretation.

A UK article identified several negative findings related to temporary nurses, e.g. wards with heavy work loads and absenteeism utilise more temporary nurses, are more expensive, because agency nursing costs are added to the wards' costs of having to pay permanent nurses in their absence. Furthermore, temporary staff may disrupt ward routines and diminish service quality by engaging in non-nursing activities, making the running of the ward not effective (Hurst & Smith, 2010:292, 294). While the study provides valuable insights, it has limitiations in that the authors: (i) analysed all-year-round data and did not focus on the summer season when temporary staff have a greater impact on especially the London-area hospitals, (ii) did not collect vacancy data from participating wards to determine reasons for the utilisation of temporary nurses, and (iii) did not talk to ward managers and nurses to obtain important insights (Hurst & Smith, 2010:292).

The literature thus indicates that many countries share and experience similar concerns regarding the utilisation of agency nurses. The concerns may be better managed by developing policies on the management of contracts, agreements and terms of reference.

2.3.7 Policies guiding agency nursing

It is important for the public health sector to have contracts in place to guide the relationship with nursing agencies.

Nursing agencies' exploitation of the public health sector as well as the opportunistic behaviour of nursing agencies in England, for example, demonstrate the pertinence of having contracts, agreements, quality checks, and improved internal nursing requirements in place (Lonsdale, Kirkpatrick, Hoque & de Ruyter, 2010:810-814).

2.3.7.1 United Kingdom

Nursing agencies are businesses who find work for nurses and offer irresistable payment packages by charging employers commission.

Many agencies entice nurses to join their companies with attractive propositions such as free transport, lottery tickets and shopping vouchers. (Northcott, 2002:10).

Given the high costs of agency nursing, the NHS is subjected to widespread exploitation and opportunism as described above. Its managers had to develop a national strategy for the nursing agency industry, focusing on the sensible use of e-auctions, framework agreements, monitoring and clinical audits in order to manage some agency managers' inclination towards exploitative and opportunistic business behaviour. Such behaviour includes overstated invoices from agencies, different fees for different employers, imprecise descriptions of nurses' competencies for differences in price, supplying specialist nurses at higher rates of pay when not having been requested (Lonsdale, Kirkpatrick, Hoque & de Ruyter, 2010:800-802, 807). The model for dealing with the phenomenon has certain key features based on the following assumptions: (i) a significant minority of agency managers engage in widespread exploitation and dishonest behaviour, (ii) the benefits versus cost of exploitative and opportunistic behaviour determine agency managers' inclination to engage in such behaviour, and (iii) the positive effect of use of contracts to manage and limit such behaviour (Lonsdale, Kirkpatrick, Hoque & de Ruyter, 2010:800-802, 807)

As a result, in 2001, the UK Department of Health's Purchasing and Supply Agency (PASA) engaged with employers, offering support and assistance to improve the management of supply agency contracts. PASA's development and introduction of a framework for agreements, quality audits, as well as improved in-house management of nursing requirements, generated favourable results. By 2004, one employer reported that agency commissions were reduced from 38% to12%, while another employer reported a reduction of 25%. In addition, agencies' scope to exploit employers have been limited, leading to lower average agency rates and improved adherence to quality and safety standards (Lonsdale, Kirkpatrick, Hoque & de Ruyter, 2010:810-814).

The UK has thus taken concrete steps to improve the management and monitoring of their agency nursing purchasing processes in order to reduce expenditure. These actions reportedly resulted in significant efficiency gains for NHS employers.

2.3.7.2. Australia

There is a paucity in literature providing in-depth discussions on policy-related findings on agency nurses and agency nursing in Australia. The results from a 2002 telephonic survey of 30 acute care hospitals and six nursing agencies in Melbourne revealed that the majority of hospitals (24) had policies for agency nursing in place, e.g. checking professional registration, length of shifts, employment conditions, orientation and incidents involving agency nurses. It also revealed that one hospital had no policies in place and only one hospital had a written policy concerning the evaluation of agency nurses' competency, performance and length of shifts (Peerson, Aitken, Manias, et al., 2002:508).

For agencies, it was reported that only one had a policy on the cancellation of shifts, one agency had a clinical educator to support its nurses, four of the six agencies had a Code of Conduct, and one other agency had regular appointments with hospitals to discuss their nurses' performance (Peerson, Aitken, Manias, et al., 2002:508). It is also noted that agencies reported that they assigned nurses according to timing of demands and not according to their qualifications and experience.

Due to the paucity of studies, it is not clear what the most current state of affairs is regarding these policies from the above reported findings alone.

2.3.7.3 South Africa

The literature indicates that contracts, agreements and quality checks are in place in SA. The role and influence of the WCGH Provincial Nursing Strategy on shaping policy relating to agency nursing, and by implication contractual arrangements, are described below.

2.3.7.3.1 WCGH Provincial Nursing Strategy

The WCGH: Provincial Nursing Strategy: 2016-2030 document serves as a blueprint for guiding the WCGH to achieve the outcomes of its strategic priority focus areas. One of the priorities, *Nursing leadership and governance,* can be applied to agency nurses and has the following objectives: (i) to ensure uniformity in the quality of nursing practice, (ii) to provide clarity on the interpretation and application of different scopes of nursing practice, (iii) to provide support, supervision, mentoring and coaching, and

(iv) to provide clarity on roles and responsibilities of nursing managers, especially ward managers (WCGH: PNS, 2016:14-16). This strategic priority for the WCGH is summarised below.

This strategic priority strengthens the WCGH efforts to guide the procurement and utilisation of nursing agencies and agency nurses. Nursing agencies are procured via a bidding process. Successful agencies are then required to sign contracts that stipulate the terms and conditions of the contracts, as well as the terms of reference (WCGH Bid document, 2010:1). The terms of reference include, but are not limited to, the obligations of nursing agencies, agency nurse shifts, SANC registration status, Nursing Information Management System (NIMS), pricing, payment, legislative requirements, performance monitoring and penalties for transgressions (WCGH Bid Document, 2010:8-13).

Evidence of contractual arrangements between the public, private health sectors, and agencies are described in a 2011 national survey that was conducted of 52 nursing agencies, to determine the characteristics of nursing agencies and their relationship with the healthcare service.

The survey results indicate the significant disproportion of contractual arrangements that exist between nursing agencies and their clients, e.g. formal agreements with the public sector were very low (16%) compared to the private sector (84%). Less than 50% of nursing agencies had a client complaints procedure for the public sector, which was substantially less compared to the agencies' private sector clients. Similar disparities were revealed for the existence of a code of conduct for the agency nurses. In addition, the results also exposed some nursing agencies who fail to do important verification checks such as nurses' SANC registration status and reference checks with former employers (Olojede & Rispel, 2015:80-81). The study findings clearly indicate a need to strengthen contractual arrangements, including monitoring there-of, between public sector healthcare institutions and nursing agencies for improved regulation of the business relationships that exist between the parties.

It is of concern that many agencies fail to do basic quality checks (Olojede & Rispel, 2015:81-82). There is thus a need for tighter management and regulation, monitoring,

and evaluation of nursing agencies, because it has important policy implications and health consequences for both clients, and the entire health system in general, and the WCGH in particular.

2.3.7.3.2 Policy developments within the nursing agency industry in SA

Many nursing agencies have been established in response to the nursing shortage. The rise in the number of agencies created a need for the establishment of an association to which agencies could subscribe to, leading to the creation of the Association of Nursing Agencies of SA (ANASA) in 1994 (Jooste & Prinsloo, 2013:2) which is the coordinating body for nursing agencies in SA.

In 2010, ANASA changed its name to the Allied Healthcare Association of SA (AHASA) when the organisation decided to allow other healthcare professional agencies to be associated with them. Table2.1 summarises the objectives.

Table 2.1: ANASA/AHASA objectives (Jooste & Moolman, 2013:2; AHASA, 2019)

MAIN OBJECTIVES OF ANASA IN 1994, INCLUDED:	PRIMARY OBJECTIVES OF AHASA
• Provide a service to, and represent, all nursing agencies in SA.	• Build strong relationships with other credible organisations.
• Provide a service to the public through competent nurses.	• Receive recognition from prominent institutions.
• Ensure credibility and recognition by healthcare institutions that use agency nurses.	• Be of service to healthcare professionals, healthcare sectors and more specifically healthcare agencies in S.A.
• Improve the standards for nursing agencies in order to provide an adequate and competent nursing workforce to hospitals.	• Ensure compliance throughout its membership.
	• Serve as an ethical facilitator between member agencies, institutions and personnel.

MAIN OBJECTIVES OF ANASA IN 1994, INCLUDED:	PRIMARY OBJECTIVES OF AHASA
	• Be self-governing through appropriate partnerships with relevant statutory bodies
	• Improve South African healthcare standards with CAPES (Confederation of Associations in the Private Employment Sector) Membership,
	• Assist in the development of skilled and professional healthcare staff.

The AHASA objectives indicate the association's desire to build relationships with its clients. Being a health human resources provider, it is expected that the association would value skills development and ethical practices. It also emphasises quality through compliance and maintaining standards. The then ANASA was instrumental in formulating an accreditation programme for nursing agencies through the development of standards for nursing agencies in South Africa. A nursing agency standard is defined as an explanation of the expected quality of management actions for a nursing agency (Muller, 2001:22-23).

Twelve standards, with resultant criteria, were developed as summarised in table 2.2.

Table 2.2: Standards for nursing agencies in SA (Muller, 2001:29-35)

STANDARDS FOR NURSING AGENCIES IN SA			
Strategic framework	Contracts	Communication	Statistics, records
Management	Affiliation, cooperation	HR management	Quality improvement
Financial management	Policies, procedures	Risk management	Marketing

The importance of contracts to regulate the business relationships is supported in literature (Lonsdale, Kirkpatrick, Hoque & de Ruyter, 2010:803). A contractual arrangement is an important first step in concluding business transactions. Given the role of contracts in regulating business relationships and conduct between entities, the standards for nursing agencies contain the important characteristics that should be included in a contract between a nursing agency and client, e.g. corporate governance

(general-, financial-, risk- and people management, administration, policies and procedures) and clinical governance (risk management and quality improvement).

Based on the organisation's objective of *compliance throughout its membership,* it is accepted that all AHASA member nursing agencies have these standards in place. In view of the fact that AHASA membership is voluntary, an in-depth comparison between these standards and the WCGH's contracts and terms of reference would provide evidence of the extent to which important policies for agency nurses and nursing are addressed to ensure safe practices in WCGH facilities.

This section concludes the general overview, and proceeds to a global overview of agency nursing.

2.4 GLOBAL OVERVIEW

The following studies evaluate the utilisation, cost, and strategies used to employ agency nurses as well as availability and implementation of policies and directives that are in place to guide agency nursing in the relevant countries.

2.4.1 United States of America (USA)

American hospitals have adopted various strategies to respond to nursing shortages, e.g. mandatory overtime, adapting their staffing to high vacancy rates by utilising agency nurses, and the use of internal float pools or nursing banks (Bae, Mark & Fried, 2010:333; Adams, Kaplow, Dominy & Stroud, 2015:52).

Mandatory overtime is calculated at permanent staff's baseline salaries and, therefore, more costly for hospitals. Thus, although the hourly cost of agency nurses may be higher, it provides for readily available nurses where hospitals have access to agency staff, because hospitals can then avoid paying the more costly employee benefits. In addition, hospitals would also not have to pay their permanent staff for unwarranted hours of work (Sukyong and Spetz, 216).

"Demand for temporary agency nurses and nursing shortages" is a USA research study done to examine how nursing shortages affect hospital managers' decisions about the ideal mix of permanent and agency nurses (Sukyong & Spetz, 2013:216,

217, 219, 224). Financial data, staffing data and temporary (agency) nurse utilisation data from general, acute hospitals in California was gathered and analysed using the generalised linear model (GLM) and the GLM with fixed effects. The study revealed a four-fold rise in the number of temporary nurses in relation to the total number of registered nurses between 1993 and 2002 and associated increased demand for temporary nurses when registered nurse benefits were increased. (Sukyong & Spetz, 2013:217, 222-224). This indicates that demands and utilisation for agency nurses continue to demonstrate a steady upward trend during that period. This is supported by literature (McIlroy, Billenness, Carter & Kinsky, 2016:12, 19).

Although the study grants insight into the phenomenon of agency nursing, the authors limited their analysis to hospitals in the California State only, which is only one of 50 USA states (Sukyong and Spetz, 2013:219). Furthermore, although the study was published in 2013, fairly outdated data was used from the period 1993-2002. While their study alluded to the fact that the nursing shortage was a cause for the growth in agency nursing utilisation, it did not address reasons for the nursing shortage.

The steady rise in the demand for agency nurses in the USA is reflected in a reported increase of 37.9% of nurses working for a temporary agency between 2000-2004, and a further increase from 2.3% to 3.2 between 2004-2008 (Adams, Kaplow, Dominy & Stroud, 2015:1, quoting the US Department of Health and Human Sciences, 2006). Despite this rise in agency nursing agency nursing in the USA, which offers the benefit of flexibility and a higher hourly remuneration, no employee benefits are provided (Adams, Kaplow, Dominy & Stroud, 2015:51).

Emory Healthcare, a university-based health care system in the USA comprising of six hospitals, implemented various cost-saving measures by reducing the utilisation of agency nurses, making the best use of their existing nursing staff, reducing overtime, and increasing efficiency by establishing an internal nursing bank. The majority of nurses recruited for this bank were registered nurses. Registered nurses as a category comprise a significant number of agency nurses and are in high demand (Sukyong & Spetz, 2013:218; Adams, Kaplow, Dominy & Stroud, 2015:51; Bae, Mark & Fried, 2010:333).

The creation of an internal nursing bank produced significant efficiency gains for Emory Healthcare, e.g. a reduction of 26,062 hours in agency nurses for corresponding quarters one to three for 2013 and 2014 respectively. The study findings report that this incurred a significant saving of USD 1,170,738.47.
The findings also report efficiency gains through the reduction of overtime (Adams, Kaplow, Dominy & Stroud, 2015:51, 54, 56). It appears that the company's implementation of an internal nursing bank was succesful enough to ensure these huge cost savings.

Table 2.3: Efficiency gains for Emory Healthcare (Adams, Kaplow, Dominy & Stroud, 2015:58).

Goal	Actual outcome
Reduction in external agency staff utilisation	Hours decreased from 113,085 for quarters 1-3 for financial year (FY) 2013 to 87,022.75 in the same quarters for FY 2014.
Cost savings from external agency staff utilisation	Through quarter 3 FY 2014, realised cost savings of USD 1,170,738.47.
Cost savings from overtime reduction	Through quarter 3 FY 2014, hours were reduced by 5,322; a saving of USD 265,355.

2.4.2. Australia

Australian hospitals have adopted a combination of strategies to respond to nursing shortages, i.e. 100% full-time workforce, a nursing pool or bank as well as flexible work patterns by utilising agency nurses (Peerson, Aitken, Manias, et al., 2002:505; Becker, McCutcheon & Hegney: 2010:46; Batch, Barnard & Windsor, 2009:20). Maintaining a core workforce, together with the ability to supplement staffing with agency nurses according to demand, is an effective human resource strategy in Australia and it appears to be mutually beneficial to both hospitals and agency nurses (Becker, McCutcheon & Hegney: 2010:46; Batch, Barnard & Windsor, 2009:21).

Another Australian study titled the "*Casualisation in the nursing workforce – the need to make it work*" states that the shift from mostly full-time, permanent employment to an increased number of casual, agency and part-time work has risen to a level where approximately one in four Australian employees are classified as being engaged in some form of casual work and is reportedly one of the highest rates in the

industrialised world (Becker, McCutcheon & Hegney: 2010:46). This is supported by the fact that 49.8% – almost half of the Australian nursing corps – worked as part-time or casual nurses in 2008 (Shacklock & Brunetto, 2012:36; Batch, Barnard & Windsor, 2009:21). This figure is ranked highest, based on the statistics of the countries which were considered for this study.

A 2014 study highlighted the cost related with agency nurses in Australia. Data was collected from 62 general medical, surgical or mixed wards in 11 hospitals across three states, to collect turnover and cost data from nursing unit managers. The cost of replacing permanent staff with short-term, temporary staff constituted more than 80% of direct overall costs and 44.4% of the cost for filling vacant positions (Roche, Duffield, Homer, et. al, 2014:7). These costs were made up of salaries, agency nurses' allowances, agency booking fees, time spent on arranging agency staff and salaries associated with permanent staff's time to orientate and coach agency staff (Roche, Duffield, Homer, et. al, 2014:8).

With a 2002 telephone survey among 30 acute care hospitals and six agencies to obtain information on the utilisation of agency nurses in Melbourne, 24 hospitals reported that they had policies for agency nursing. These policies related to checking the nurses' registration status, conditions of employment, orientation to the hospitals, length of shifts and handling of incidents concerning agency nurses. Only one hospital had a written policy to evaluate agency nurses' skills and performance. Seven hospitals had policies addressing the administration of medication, the handling of drug keys, care of complicated patients, and rules for taking charge of wards (Peerson, Aitken, Manias, et al., 2002:508).
Although this was a small-scale study, it highlights the importance of policies and directives to effectively monitor and improve the management of nursing agencies.

2.4.3 United Kingdom (UK)

In response to the nursing shortage, hospitals in the UK utilise a flexible staffing strategy where three types of temporary nursing staff fill vacancies to meet the service needs, i.e. (i) bank nurses are the hospital's own nurses who work extra hours through the hospital's own nursing agency, or through the National Health Services (NHS), (ii)

permanent staff who work remunerated overtime, and (iii) agency nurses who work through nursing agencies.

In the UK, 25% of nurses employed in the NHS are absent from work due to sickness, study leave, annual leave or maternity leave, and have to be replaced, hence the need for temporary staff (Hurst & Smith, 2010:287, 289). The incidence of agency nursing was illustrated in a 2013 survey and a 2016 study. The 2013 survey indicated that more than half (54%) were doing doing additional nursing shifts, and five years later, 47% of participants admitted to doing bank and agency work (Russo, Fronteira, Jesus & Buchan, 2018:5) . This is supported by The Royal College of Nursing and HCL Nursing, study, which indicates that the majority were doing part-time employment besides their full-time public sector employment (McIlroy, Billenness, Carter & Kinsky, 2016:12, 19). Thus, the iterary evidence indicates that agency and bank nursing occurs in significant numbers in the UK.

Nurses working through an agency in the UK are paid higher rates and, therefore, more nurses opt to work on a temporary basis (Hurst & Smith, 2010:288-289). A perceived benefit for hospitals is the NHS option, because it is the most affordable of the three temporary nursing supply options and utilising temporary nurses via the National Health Service (NHS) may incur greater savings than utilising the other two options if hospital managers do careful workforce planning and factor in the use of temporary nurses (Hurst & Smith, 2010:289). Although agency and bank nurses are paid higher hourly rates, thus making it more affordable for hospitals, it made up between 5%-52% of hospital nursing costs in England in 2010. In 1997-1998 it was £25m, in 2000-2001 it was £35m and by 2007-2008 it has escalated to £883m.

These reported findings were based on document analysis, non-participant observations, ward activities, and patient and staff interviews in 605 general and specialist wards between 2004 and 2009 (Hurst & Smith, 2010:287-288). However, the expenditure of £25m in 1997-1998 is in sharp contrast to a spending of £216m for 1997-1998 in England as reported by De Ruyter (2007:1666). In addition, Hurst & Smith's (2010:288) reference to the 2000-2001 expenditure of £35m for England differs markedly from that of Tailby (2005:371) who reported an expenditure of £810m for bank nurses in England and Wales for 2000. The researcher could not find a

rational explanation for this discrepancy even though both De Ruyter and Hurst & Smith reported these costs for England while Tailby mentions only England and Wales.

The literature thus indicate that, although the utlisation of agency nurses from the NHS is more affordable, it remains very costly, hence the efforts to reduce agency rates and assignments (de Ruyter, 2007:1670). Nursing agencies are businesses who find work for nurses and offer irresistable packages of pay by charging employers commission.

Many agencies persuade nurses to join their businesses with more attractive offers like free transport, lottery tickets and shopping vouchers. However, all these attractive benefits come at a cost, which means that shifts cost the NHS significantly more (Northcott, 2002:10). Given the high costs incurred with agency nurses, the NHS was exposed to widespread exploitation and opportunism as described above. Its managers had to develop a national plan for the nursing agency market focusing on the use of e-auctions, framework agreements, monitoring and clinical audits in order to manage some agency managers' disposition for exploitative and opportunistic conduct. Such conduct included overstated agency invoices, different charges for different employers and vague descriptions of nurses' competencies, which led to differences in price (Lonsdale, Kirkpatrick, Hoque & de Ruyter, 2010:800-802, 807).

The UK National Plan's model to address the issue certain fundamental features based on the following assumptions: e.g. (i) a significant minority of agency managers engage in widespread exploitation and opportunistic behaviour, (ii) the benefits versus cost of exploitative and opportunistic behaviour determine agency managers' disposition to engage in such behaviours, and (iii) the use of contracts should be employed to manage and limit such behaviours. Thus, in 2001, the Department of Health's Purchasing and Supply Agency (PASA) engaged with employers, offering support and assistance for improved management of supplying agency contracts. PASA's development and implementation of a framework for agreements, quality audits, as well as improved in-house management of nursing requirements, yielded favourable results (Lonsdale, Kirkpatrick, Hoque & de Ruyter, 2010:813).

By 2004, one employer reported that agency charges were reduced from 38% to 12%, while another emplyer reported a reduction of 25%. In addition, agencies' chances of exploiting employers had been limited. This led to lower average agency rates and improved adherence to quality and safety standards (Lonsdale, Kirkpatrick, Hoque & de Ruyter, 2010:810-814).

The UK has thus taken concrete steps to improve the management and monitoring of their agency nursing procurement processes in order to reduce expenditure. These actions reportedly resulted in significant efficiency gains for NHS employers.

2.5 LOCAL OVERVIEW OF AGENCY WORK - SA

This section provides a review of local research studies discussed under the following headings:

- Utilisation of agency nurses
- Cost of utilising agency nurses
- Nurse to patient staffing ratios (staffing norms)
- Community service professional nurses and agency nursing
- Legislation about temporarycontract workers
- District hospitals – what makes them unique?

2.5.1 Utilisation of agency nurses

SA follows the international trend of flexible work arrangements by utilising agency nurses, moonlighting and bank nurses as a human resource strategy to manage the shortage of nurses in its healthcare institutions (Engelbrecht, Rau, Nel & Wilke, 2019:2; Rispel & Moolman, 2015:2, 6; Mabuda, 2018:2).

Moonlighting and agency nursing are common in SA. A 2010 study of 80 hospitals conducted in four provinces, i.e. Eastern Cape, Western Cape, Gauteng and the Free State revealed that agency nursing and moonlighting (37.8% and 28% respectively) occur frequently and a significant number of nurses (69.2%) performed either overtime, moonlighting or agency nursing in the 12 months prior to the study (Rispel, Blaauw, Chirwa & De Wet, 2014:3). This amounted to 4 in 10 nurses in the four provinces having moonlighted or worked through a nursing agency during this period

(Rispel & Blaauw, 2015:50). This indicates that the various forms of temporary work occurs in high numbers in South Africa.

2.5.2 Cost of utilising agency nurses

The cost associated with the utilisation of agency nurses has been highlighted in the international literature under subsections 2.4.1-2.4.3. This is discussed below in order to understand the potential impact on the staffing budgets of, and implications for, hospitals and nurse managers in district hospitals in the Cape Metropole.

2.5.2.1 Direct cost

The widespread utilisation of agency nurses in SA was highlighted in a 2014 survey determining the utilisation and direct costs of nursing agencies in the SA public health sector from 2005/6 to 2009/10. The survey was conducted in all nine SA provinces. Five provinces indicated that they utilise agency nurses. One province did not participate in the survey, two indicated that they do not use agency nurses and another province stated that it stopped the practice due to budgetary constraints (Rispel & Angelides, 2014:4).

However, the authors report that, even though only five provinces indicated that they utilise agency nurses, the financial records of all nine provinces reflected agency nursing expenditure, e.g. the North-West Province's 2008/9 financial year revealed agency expenditure of 15.13%, which was the highest of all nine provinces' agency expenditure. Possible reasons for discrepancies in the provinces' reporting of utilising agency nurses are: (i) incorrect financial entries, (ii) the utilisation of agency nurses may indicate the extent of staff shortages, especially in the rural areas of the province, and (iii) agency staff is paid from the goods and services budget and the payment for nursing agency services may have been an endeavour to hide overspending on the staffing budget while there was evidence of an estimated 743 vacant nursing posts (Rispel & Angelides, 2014:1, 7-8).

The study findings further reveal that the country's public sector agency cost increased from R914.29 million in 2005/6 to R1.49 billion by 2009/10, totalling R6.47 billion for the 5-year period. The total amount was enough to, as an alternative, appoint either 5369 Professional Nurses, 9 636 Enrolled Nurses or 12 441 Enrolled Auxiliary Nurses (Rispel & Angelides, 2014:6-7). The findings are significant, because it highlights the

financial impact of agency nursing on the health budgets of provincial health departments. However, the direct costs represent only a partial picture of the full financial extent of agency nursing on health budgets.

2.5.2.2 Indirect cost

In a SA study conducted at two large public hospitals, the indirect costs were calculated to determine the amount of managers' time spent on the recruitment and management of agency nurses. Indirect costs measured were defined as the number of hours spent on pre-employment checks, recruitment, orientation and supervision (Rispel & Moorman, 2015:1). The study findings are summarised in Table 2.4 :

Table 2.4: Estimated weekly time spent on recruitment and management of agency nurses for the 2009/10 financial year (Rispel & Moorman, 2015:5).

Element	Hospital 1	Hospital 2
Direct costs in SA Rand, or	R38.86 million	R10.40 million
% of the personnel budget	5.34%	4.14%
Selected indirect cost element in hours/week:		
Identify need for agency nurses	1	4
Recruiting an agency nurse	10.5	20
Orientation	2	8
Supervision & dealing with managing problems	28	20
Verification of invoices	0	4
Processing of invoices	10	4
Indirect costs as total hours/week	**51.5**	**60**
Estimated monetary value of time spent/week	R962 267.00	R300 121.00

The indirect costs per week surpassed the direct costs for both hospitals. It must be mentioned that, according to the study, the total hours per week were calculated on the understanding that managers worked 40 hours per week.

Furthermore, nurse managers as well as administrative staff are involved in the administration of agency nurses, e.g. clerks in finance who attend to invoices (Rispel & Moorman, 2015:5).

The findings provide surprising insights into the direct and indirect costs associated with agency nurses. Unless a detailed costing is done to calculate indirect costs, it

would remain difficult to quantify the total cost to hospitals. Knowledge of the total costs may influence nurse managers' decisions regarding staffing in general and the utilisation of agency nurses in particular and should, therefore, be provided for in hospital policies regarding staffing including the utilisation of agency nurses.

2.5.3 Nurse to patient staffing ratios (staffing norms)

It is the researcher's understanding that the shortage of nurses worldwide, coupled with increased patient admissions to hospitals, affect the workload of permanent nurses, causing burn-out, poor quality of care and threatens the safety of patients, continuity of care and leading to other challenges relateing to agency nurses already mentioned. (Aiken et al., 2012 in Mabuda, 2018:2). The absence of national staffing norms in South Africa contribute to the poor nurse:patient ratios, which exist (Rispel & Bruce, 2015:2).

In 2017 the National Department of Health (NDoH) published regulations to govern norms and standards for health establishments. The purpose of these regulations are to promote and protect the health and safety of patients and staff in the country (NDoH, 2017:41) The WCGH also identified a need to develop nurse staffing norms for the province (Mabuda, 2018:2). The WCGH drafted recommended nurse to patient ratios for paitients in general and psychiatric hospitals. These ratios were circulated as internal departmental correspondence in hospitals in 2018. However, these have not been implemented, because it is currently considered too costly for the WCGH to employ enough nurses to meet the nurse to patient staffing ratios.

Thus, the nursing shortage continues to be felt in the WCGH facilities, which neccessitates the continued utilisation of agency nurses. However, community service professional nurses enter WCGH facilities regularly to offer some relief for the nursing shortages experienced.

2.5.4 The use of community service professional nurses and agency nursing

By law, every South African professional nurse (PN) who complete the four-years of nursing studies and who whishes to register with the SANC, is required to perform paid community service for one year at a public health facility (SANC, 2020:1).

Thus, many WCGH facilities, including district hospitals, employ new community service PN's annually.

In the researcher's experience, such nurses' registration status with the SANC is not generally interpreted as them being fully registered PN's yet. In practice, when they have completed their community service year, their completion of community service has to be signed off by the head of the facility, to indicate to the SANC that they are competent PN's who are able to practice as independent practitioners. Thus, until they have obtained full registration, nursing agencies do not utlise community service PN's to amplify their pool of available nurses. They are, therefore, not available to do agency nursing.

It was however observed, that they are, available to perform, and are frequently utilised, to perform overtime work in their own facilities of employment. Thus, although overtime rates of pay in South Africa are generally higher than agency nursing rates, the use of these PN's may be beneficial, because they know the routine policies and procedures of their own facilities, which implies that they would be more productive when performing overtime work.

The researcher is aware of instances where PN's accept temporary contract work after completion of their community service while waiting for permanent employment. The duration of contracts is regulated by law in South africa.

2.5.5 Legislation about temporary contract workers

A major change to temporary employment laws in South africa came into force in 2014 with the promulgation of the Employment Services Act (4 of 2014) to regulate employment services, including temporary employment agencies (Shoba, 2016:ii). This as important implications for the WCGH as an employer, because under this law, any person who is employed on a contract for longer than three months without justifiable reasons, is deemed to be a permanent employee.

As observed, agency nurses may work at a facility for a single shift, or more shifts and this sceduling is based on the demand for additional nursing skills to provide adequate, quality care to patients.The nursing agency is regarded as the agency nurse's employee and the nurse's services are procured based on demand.

Thus, the agency nurse's scheduling at a WCGH facility may not neccessarilly be regarded as a contractual arrangement between the agency nurse and the WCGH, but rather a contractual arrangement between the nursing agency and the WCGH. This differs where there is a contract of employment, which would place the contract worker in the employof the WCGH.

In practice, the WCGH nurse manager usually assumes full responsibility for the performance and professional conduct of an agency nurse who performs agency work in a WCGH facility This could be considered a liability for the WCGH when an agency nurse causes harm to a patient, because the patient was in the care of the WCGH when harm was caused. It is for this reason that hospitals may not generally offer contract employment to agency nurses, and instead opt to source their services only when the need arises. The strategy to opt for agency nurses might be to limit a hospital's liability related to perceived disadvantages of using agency nurses whose conduct and clinical skills may be unknown and who may not be familiar with the facility, its policies and procedures.

2.5.6 District hospitals - what makes them unique?

Relevant international literature describing district hospitals in sufficient detail could not be found. Therefore, district hospitals in the SA context will be described.

The organogram of the WCGH places district hospitals in Programme 2 (sub-programme 2.9) under the management of a Chief Director. District hospitals render 24-hour District Health Services (DHS) to its surrounding populations and act as referral hospitals for clinics, community health centres, district hospitals and community-based district health services (CBS) (WCGH 2016/17:25, 45).

The hospitals vary greatly in size by number of beds and are doctor-driven, nurse-supported acute-care facilities offering the following preventive, promotive and curative services: (i) mother and child services, (ii) general medical and surgical services, (iii) gynaecology and obstetrics, (iv) casualty and emergency care, (v) out-patient services, and (vi) certain specialist services provided via outreach services by specialists from general specialist (level 2) hospitals (Western Cape Government:

Health, 2017:25, 45). The hospitals included in this study are in the Cape Metropole DHS.

2.6 MANAGERS' VIEWS ON AGENCY NURSING

The focus of this study explores nurse managers' views on the utilisation of agency nurses. The views of other nurse managers are important because it may provide a backdrop from which we may gain valuable insights in nurse managers' views in the Cape Metropole district hospitals. However, there is a paucity of studies globally over the past 10 years that focus on the views of nurse managers in acute-care hospitals regarding the utilisation of agency nurses.

2.6.1 Australia

An Australian study, conducted in 2003, interviewed seven nurse managers, a human resources manager and three nursing agencies in two acute-care hospitals, one public and one private, in Melbourne and reports on their perceptions of agency nurses (Manias, Aitken, Peerson, et al., 2003:460).

The findings reveal that nurse managers spend a considerable amount of time planning and sourcing both skilled permanent nurses as well as agency nurses, especially for speciality areas agreeing with the findings reported by Peerson, Aitken, Manias, et al. (2002:507-508).

One public hospital nurse manager expressed concern regarding agency nurses' communication, based on prior experience. Both public and private hospital nurse managers held the view that agencies and agency nurses should assume sole responsibility for professional development, because the hospitals' clinical educators priority was permanent hospital staff.

Furthermore, the nurse managers believed that agency nursing did not provide a career pathway, especially for newly qualified nurses, because of a lack of professional support for these nurses after graduation form nursing schools. In addition, nurse managers did not hold a view that agency nurses were part of the healthcare team because of the short-term nature of their work (Manias, Aitken, Peerson, et al., 2003:461-464).

Despite the seemingly negative perceptions, nurse managers indicated that the quality of agency nurses was high and comparable with that of permanent nurses, as expressed in the following statement: *"The quality of agency nurses, as much as I hate to admit this, is quite high because there are a lot of good nurses out there doing agency"* (Manias, Aitken, Peerson, et al., 2003:463-464).

2.6.3 UK

An investigation into agency and bank nursing was conducted with nine senior and six ward managers in an English metropolitan area in 2001. The aim was to explore the rise in agency and bank nursing and the implications for workplace relations as well as nurses' work life quality.

The findings indicate that all managers preferred to work with permanent staff and regarded agency nurses as challenging because of cost, quality and human resources management. Their employing body had a formal policy preferring the implementation of flexible working hours to accommodate staff requests to balance their work and family commitments. This implies that, although they supported this policy, nurse managers had to arrange staffing of three eight-hour shifts over a 24-hour period (Tailby, 2005:375-376). One nurse manager expressed the following view:

> *"Managers at interview panels promise people flexibility and people like me are left to pick up the pieces. They make all these promises that actually don't work for the wards and actually put pressure on us"* (Tailby, 2005:376).

There appears to be a general preference among NMs for bank nurses as opposed to agency nurses, because bank nurses are more frequently utilised and had, therefore, already been evaluated for their competency. In addition, the NMs expressed the opinion that bank nurses were generally more aware of the hospital procedures due to their frequent placement at the hospital. Furthermore, their hourly rates were lower than those of agency nurses (Tailby, 2005:376).

2.6.4 South Africa (SA)

The views of hospital- and NMs have been explored regarding the direct and indirect costs of agency nurses in two public sector hospitals in a study that was done between 2005-2010. Three themes emerged from this study influencing the cost and corresponds with that identified by Tailby (2005:375), i.e. human resources issues,

quality of care, and cost. Human resource issues included poor attitudes, unreliability, a perceived lack of commitment, poor relationships with doctors, disloyalty, reluctance to do certain duties, and the perception that agency nurses lack a caring attitude. It has been observed that NMs' perception of poor-quality care was not validated by any evidence in the study. However, the authors state that their perceptions may be justified, referring to studies done in the USA and UK, indicating that agency nursing contributes to poor patient care quality (Rispel and Moolman, 2015:7).

Other issues regarding agency nurses were also identified as problematic, i.e. (i) the short placement period in wards made it ineffective and, therefore, very little time is spent on induction and orientation, (ii) agency nurses required substantially more supervision with clinical duties and recordkeeping than permanent staff (Rispel & Moolman, 2015:4-5).

The WCGH's DNS states the supplementary challenges that include a perceived lack of required competencies, lawsuits due to medico-legal hazards, increase in patient complaints, poor attitude, lack of reliability, and tired, burnt-out employees due to working unregulated working hours (WCGH Provincial Nursing Strategy: 2016-2030, 2016:8).

The studies indicate that, although hospital and nurse managers utilise agency nurses as an acceptable human resource strategy to meet staffing requirements and patients' needs, they have specific views and perceptions about them. At least two studies have identified similar emerging themes, i.e. quality of care, human resources issues and cost, and two studies mention that the short-term placement of agency nurses had implications for proper induction, orientation and familiarity with policies, procedures and continuity of care.

2.7 CHAPTER SUMMARY

The literature review aimed at providing insight into the phenomenon and significance of agency nursing against the backdrop of the nursing human resource crisis. The following themes emerged: the origins, incidence, different forms and reasons for undertaking agency work, benefits as well as concerns, dilemmas faced by nursing and health managers, policy issues, nurse and health care managers' views, and

perceptions associated with agency nursing followed by general, global and local overviews.

Literature indicates that the utilisation of agency nurses has become part of the routine workforce in many health facilities worldwide. The UK and Australia reported high agency nurse utilisation rates. Furthermore, the full extent of utilising agency nurses become apparent when both the direct, as well as indirect costs are calculated

Chapter 3 describes the research methodology applied to explore nurse managers' views on the utilisation of agency nurses.

CHAPTER 3
RESEARCH METHODOLOGY

3.1 INTRODUCTION

Chapter 3 describes the research methodology that was used to explore nurse managers' views on the utilisation of agency nurses in district hospitals in the Cape Metropole. It also describes the aim and objectives of the study including the study setting, population and sampling, pilot interview, data collection, data analysis, rigour in qualitative research, and ethical considerations.

3.2 RESEARCH QUESTION

What are nurse managers' views on the utilisation of agency nurses to augment nurse staffing at district hospitals?

3.3 RESEARCH AIM

The aim of the study was to explore nurse managers' views on the utilisation of agency nurses in district hospitals.

3.4 RESEARCH OBJECTIVES

The objectives of the study were to describe:

- Common practices pertaining to the utilisation of agency nurses
- How nurse managers deal with budgetary restrictions pertaining to agency nurses
- How nurse managers deal with the provision of quality nursing care when utilising agency nurses.

3.5 STUDY SETTING AND PARTICPANTS

The Western Cape Government: Health (WCGH) has 34 district hospitals with a total of 2 925 beds. These hospitals are grouped under (i) Rural District Health Services (RDHS) and (ii) Metro District Health Services (MDHS) and are located throughout the Western Cape Province.

District hospitals render the following services to the uninsured population, i.e. community members without medical aid, including those who are unable to afford cash payment for private hospital services: child and adult in- and out-patient general

medical and surgical health services, emergency medical care, general obstetric services and selected general specialist services. The general specialist services are delivered by medical specialists from the general specialist hospitals who do planned outreach services on a monthly basis to the district hospitals (WCGH: 2017-18:33). The district hospitals are generally doctor-driven, nurse-supported, in-patient 24-hour facilities in which the clinical departments are headed mainly by family physicians. They serve as referral hospitals for surrounding clinics, Community Day Centres (CDC's) and private doctors who often refer cash-paying, but medically uninsured, patients who cannot afford private in-patient hospital care.

Three public specialist hospitals, one public general specialist hospital, eight district hospitals and various CDC's and clinics are located in the Cape Metropole and serve the uninsured population of the total Cape Metropole population (WCGH: Provincial Nursing Strategy: 2016-2030:2). The table below provides a summary of the population estimate for the Cape Metropole.

Table 3.1: Population estimate for the Cape Metropole (WCGH Annual Performance Plan 2015/16).

	2016	2017	2018
Total population	4 067 774	4 136 346	4 200 877
Uninsured population	3 113 265	3 170 328	3 224 577
Percentage uninsured population	76.53%	76.65%	76.76

On 17 April 2018 the DNS identified the eight public district hospitals out of the 34 district hospitals in the province who utilise agency nurses on a daily basis. These eight hospitals are all located within the Cape Metropole (RDHS) and were eligible for inclusion in the study because they utilise agency nurses on a daily basis. The eight hospitals constituted a feasible and practical study population, because they were accessible and appropriate to the focus of this study. Two additional participants formed part of this study, i.e. the Allied Healthcare Association of South Africa (AHASA) and the Directorate Nursing Services (DNS) of the Western Cape Government: Health.

AHASA is a coordinating body for healthcare, including nursing, agencies in South Africa. Its member agencies subscribe to its Code of Conduct and AHASA acts as a watchdog to ensure that member agencies conduct ethical business practices. The AHASA's objectives include (i) building strong relationships with credible organisations, (ii) servicing the healthcare sector, and specifically healthcare agencies, (iii) ensuring compliance by its member agencies to its Code of Conduct, (iv) serving as an ethical facilitator between its member agencies, institutions and staff, (v) assisting with skill development of healthcare staff, and (vi) improving South African healthcare standards together with the Confederation of Associations in the Private Employment Sector (CAPES) (AHASA website). AHASA has been included in this study via a telephonic interview because they could make a meaningful contribution to complimenting the study findings.

The Directorate Nursing Services (DNS) of the Western Cape Government: Health has also been included in the study, because the DNS assumes responsibility for coordinating and directing nursing practice, education and training and plays a crucial role in monitoring and advising on the hours that nurses work using nursing agencies. The DNS is also the custodian of NIMS, which is an electronic procurement system that communicates the nursing skills needed to all WCG: Health-approved nursing agencies (WCGH: Provincial Nursing Strategy: 2016-2030:8, 12). A Director of Nursing who reports to the Chief Director, heads the DNS: People Management. The DNS participated in the study through a personal interview.

3.6 RESEARCH DESIGN

A research design is defined as a complete plan of the research project that maps out the process from conception to completion. It involves selecting the most appropriate methods to solve the problem under investigation (Du Plooy-Cilliers, Davis & Bezuidenhout, 2014:93; Anderson & Poole, 2009:22). This study utilised a qualitative approach with an explorative and descriptive design.

3.6.1 The nature of Qualitative Research

Qualitative research is a systematic scientific inquiry to clarify or enlighten the researcher's understanding of a phenomenon, e.g. describing the experience of participants (Astalin, 2013:118; Flick, 2009:16). In this study, the realities of agency

nurse utilisation were approached as the meaningful immersion in participants' experiences as expressed by themselves, i.e. recording the data and interpreting views from the participants' own opinions and perspectives. (Brink, Van der Walt & Van Rensburg, 2012:193). In addition, it is important to note that the role and responsibility of the qualitative researcher is to provide an interpretive understanding of what is learnt, understood, produced or experienced about, the phenomenon being studied, including the meaning participants attach to it and thus producing the "big picture" of that which emerges from the data (St. George, 2010:1626; Astalin, 2013:118). In other words, the qualitative researcher develops a multifaceted picture and understanding of the problem, obtains the data from various perspectives and attempts to provide a comprehensive understanding of the matter at hand (Creswell, 2013:47).

3.6.2. Appropriateness of qualitative research for this study

In line with what literature describes as appropriate, this study used a qualitative approach because: (i) nurse managers' views on the utilisation of agency nurses have not been explored sufficiently to answer the research question, (ii) a nurse manager experiencing challenges with the utilisation of agency nurses needs a complex, detailed understanding of the problem that can best be understood through direct interaction with other managers by listening to their views and understanding their contexts, and (iii) given the different methodologies, a quantitative approach with numerical analysis would not fit the problem nor answer the research question adequately (Creswell, 2013:47-48).

3.6.3 Philosophical underpinnings of qualitative research

It is important for qualitative researchers to be aware of, and understand that: (i) qualitative research begins with making certain philosophical assumptions when deciding on the research question to be answered, (ii) researchers bring their own world view or set of beliefs to the study, and (iii) researchers use descriptive and theoretical frameworks that shape the content of their studies. These three elements of the research design (assumptions, world views and frameworks) need to be addressed explicitly in any qualitative research study, because it is a requirement for good research and indicates that a researcher is aware of its effect on how the study is conducted (Creswell, 2018:15; Creswell, 2013:44).

Creswell mentions five philosophical assumptions, which influence how qualitative studies are designed and conducted: (i) *Ontology:* a position towards the nature of reality and its characteristics; qualitative researchers embrace the idea of multiple realities, (ii) *Epistemology:* in order to gain a deeper understanding of participants' realities the qualitative researcher gains first-hand experience by conducting the study alongside participants where they live and work, (iii) *Axiological assumptions:* the researcher acknowledges their own values that may influence the study and, therefore, explicitly makes known those values and biases, (iv) *Rhetorical assumptions:* refer to a writing style, which is personal in nature and based on definitions emerging from the study as defined by the participants themselves, and (v) *Methodological assumptions:* these refer to the process of basing the study findings solely on participants' input, i.e. inductive or interpreted from the bottom up (Creswell, 2018:16-19).

The researcher declares his axiological, as well as methodological, assumptions including close working relationships with nurse managers and nursing agencies who supply agency nurses, since these may influence how this study is reported (Creswell, 2013:21).

3.6.4 The research approach used for this study

The methodological assumptions are closely linked to the research design selected for this study, describing how data analysis occurs concurrently with the data gathering process, thus allowing the researcher to gain new insights into the phenomenon being studied.

This, in turn, leads to the development of new theories based on, and inferred from, the bottom up (Astalin, 20123:121; Creswell, 2018:16-19). However, the purpose of this study is to explore and describe the views of nurse managers on the utilisation of agency nurses, without the purpose of generating theory.

For this study, a qualitative research approach using a descriptive methodology was selected, because it would probably best answer the research question and meet the objectives of this study (Brink, Van der Walt & Van Rensburg, 2012:55). The research question could best be answered by listening to the participants' responses to in-depth

questions and using their own words to express their views; in this study their views on agency nurses. A qualitative approach is thus more appropriate and effective in order to gain a deeper understanding of the research topic from the viewpoint of the participants (Brink, Van der Walt & Van Rensburg, 2012:55, 120-121).

The use of a qualitative, descriptive design is a valuable and distinctive component of qualitative research. It is the preferred method for providing a concise description of a topic being studied, because it typically answers the questions of *who, what* and *where* (Sandelowski, 2000:339). A crucial factor in all scientific study is that it must accurately describe the meaning participants attach to the topic under study and it must also be inferred accurately in the context in which it occurs, in order for the study to be meaningful (Sandelowski, 2000:335-336).

(i) Philosophical underpinnings of descriptive designs

Descriptive studies typically use a general approach to qualitative and other behavioural studies involving humans and animals, namely a naturalistic enquiry. The researcher uses techniques that will allow *"...the target phenomenon to present itself as it would if it was not under study"* (Sandelowski, 2000:337).

Thus, a phenomenon is studied in its most natural state and there is no pre-selection or manipulation of study variables, nor any theoretical view regarding the study topic. The naturalistic approach, therefore, makes the qualitative researcher less compelled to adhere to specific methodologies, e.g. narrative, phenomenological and ethnographic studies (Sandelowski, 2000:337). This study was conducted at various hospitals, which is a natural, familiar environment for the participants.

(ii) Key attributes

One key attribute of the naturalistic enquiry is a focus on the findings of the research enquiry by accurately describing the participants' in-depth views on, and the meanings they attach to these views, related to the phenomenon being studied. Participants' views are described in Chapter 4.

Another key attribute is getting direct answers to questions (e.g., *who, what* and *where)* of specific relevance to the study topic (Sandelowski, 2000:336-338). For

example, the naturalistic approach allowed for the research question to be answered, namely: What are nurse managers' views on the utilisation of agency nurses to augment nurse staffing at district hospitals? In addition, with the naturalistic approach, the study objectives have been met as described in Chapter 5.

(iii) Data collection and analysis

In line with preferred data collection methods for descriptive studies, four semi-structured focus groups, one face-to-face and one a telephonic interview, were conducted in order to gain a broader perspective on, and in-depth participants' responses to, the topic being studied. These data collection techniques best answered the research question and allowed for the study objectives to be met (Sandelowski, 2000:338; Brink, Van der Walt & Van Rensburg, 2012:153). It also allowed the facilitators to ask questions for clarification and, thereby, authenticating participants' responses. In addition, it also provided opportunities to observe non-verbal behaviour and mannerisms, which have been recorded and considered during and after data collection and analysis (Brink, Van der Walt & Van Rensburg, 2012:153).

Qualitative data analysis involves the examination of a large volume of written data typically derived from recorded interviews and which needs to be transcribed. Transcriptions must be verified against the recorded interviews and, in so doing, the researcher becomes immersed in the data.

During data collection, and again during data analysis, the researcher had to make reflective notes and do memoing as meaning comes to the fore (also called simultaneous or concurrent data collection and analysis).

Data analysis then continued by finding patterns and producing explanations to categorise the data according to codes. A code is a symbol or abbreviation used to classify words or phrases. Codes are generated as data analysis progresses and are phrased closely to the words used by the participants (Brink, van der Walt & van Rensburg, 2012:193-194; Sandelowski, 2000:338).

The data analysis had to be done as guided by the research objectives and, using both Atlas.ti computer software and manual analysis, common themes emerging from the interviews were identified.

(iv) Data presentation

Sandelowski (2000:338-339) states that: *"The expected outcome of qualitative descriptive studies is a straight descriptive summary of the informational contents of data organized in a way that best fits the data"* (Sandelowski, 2000:338-339).

There are various ways in which data may be summarised and represented, e.g., in actual or reverse chronological order, according to day, week or month, or most prevalent to the least prevalent theme. However, this is not a requirement in order for a qualitative descriptive study to be considered good enough or practically valuable; it is only necessary to produce a descriptive summary of an event that presents the data well enough and that will be most enlightening to the audience for whom it was written (Sandelowski & Wolcott in Sandelowski, 2000:339).

The study findings are summarised and categorised in Chapter 4 according to the sub-sections of the interview questionnaires. The study supervisor was consulted throughout this process.

3.7 POPULATION AND SAMPLING

3.7.1 POPULATION

A study population refers to all persons or events that meet the inclusion criteria of a study (Botma, Greeff, Mulaudzi & Wright, 2010:124).

The target population of this study were all Heads of Nursing Services (HoNS), their deputies and managers of medical and surgical wards at district hospitals in the Cape Metropole. These nurse managers who have been in their positions for at least two years and been actively involved in the utilisation of agency nurses were eligible participants for this study and comprised HoNS N=6, Deputy Heads N=11and Ward Managers N=19, thus a total of 36 managers.

3.7.2 Sampling

Through sampling, the study population was then reduced to an accessible, representative group of the population available to participate in the study (Botma, Greeff, Mulaudzi & Wright, 2010:124).

Participants in the study sample were selected purposefully, because of the meaningful contribution they could make based on their knowledge, background,

experience and ability to provide a diverse range of information on the topic (Burns & Grove, 2011:313, Adams, 2017:64; Creswell, 2013:156).

The eligibility criteria included (i) nursing managers, ward managers and their deputies with at least two years' current experience in their respective roles, (ii) one representative from AHASA, and (iii) a representative of the DNS, Western Cape Government: Health who was responsible for nursing agencies. Thus, the final study sample provided representation from six hospitals and included twelve (12) nurses in managerial positions.

A stratified sample was drawn from the study population based on their expert knowledge and experience of working with agency nurses and their ability to provide in-depth answers in response to the research question and study objectives. NMs who have been in their positions for at least two years and daily worked with agency nurses were selected. Two years were regarded as a reasonable period to gain in-depth experience and insight in the phenomenon of agency nursing, which would allow participants to answer the research question and reach the objectives of this study.

Thus, the final study sample provided representation from six hospitals and included twelve (12) nurses in managerial positions. Two participants were HoNS, seven were deputies and three were ward managers including the pilot interview participants who were constituted one HoNS and two deputies.

3.7.3 Exclusion criteria

All participants who fitted the inclusion criteria, but who were either unwilling or unable to participate due to circumstances, e.g., illness or leave, were excluded from the study (Fischer, et al. 2017:52). It is important to note that twenty-four (24) of the nurse managers who did meet inclusion criteria did not participate in the study due to annual leave, sick leave or no response to invitations to participate in the study.

3.8 DATA COLLECTION INSTRUMENTATION

Literature refers to a focus group both as *discussion* and as an *interview* (Moretti, Van Vliet, Bensing, et al., 2011:421; Yan & Hu, 2019:558). De Vos (2011:360) refers to it as group interviews as a means to obtain an enhanced understanding of participants'

feelings about a phenomenon. Furthermore, focus groups allow researchers to observe and interpret participant behaviours as a contribution to the discussion (Moretti, van Vliet, Bensing, et al., 2011:427).

Semi-structured interview schedules (Appendix 4) were used in this study. The scope of the discussion guides was informed by the objectives of the study, the initial literature review, guidance from the study supervisor, and the researcher's own professional experience. The Health Research Ethics Committee (HREC) of Stellenbosch University approved the interview questionnaires. Being aware of the potential to subjectively influence the research process because of an alignment to the participants in this study, the researcher was mentored by an independent nursing academic who was skilled in group dynamics and who facilitated the first two focus group interviews in order to limit potential conflict of interest.

Having participants from different hospitals at different levels of management could potentially influence participation in the focus groups. This was discussed with the facilitator and a strategy was devised whereby the researcher acted as research assistant, identifying and managing participants' body language, active participation and contributions in the focus groups. These were discussed after the interviews and was incorporated in the final research report.
The interview schedules were drafted to obtain participants' views on the utilisation of agency nurses. The main questions were framed as open-ended with prompting questions. The last question in each interview schedule allowed for participants to make additional comments.

3.9 DATA COLLECTION

Data collection refers to a series of interrelated activities in gathering good data to answer an emerging research question (Creswell, 2013:146).

Being aware of the potential to subjectively influence the research process because of a personal alignment to the participants in this study, the researcher used a nursing academic who is skilled in group dynamics, to facilitate Focus Groups 1 and 2. in order to limit bias and a potential conflict of interest and also provide an opportunity for the researcher to enhance his skills and to become comfortable with the group facilitation

process. This facilitator became unavailable for Focus groups 3 and 4. The researcher was able to facilitate these two focus groups, but made use of a fieldworker who is also a skilled group facilitator, to act as an observer and made field notes during the interviews (Palaganas, E, Sanchez, M, Molintas, M & Caricativo, M, 2017:427). Data was collected through a pilot focus group interview and three more focus groups with the rest of the participants using a face-to-face interview and a telephonic interview. These are described below.

3.10.1 FOCUS GROUP INTERVIEWS

Marshall & Rossman (2011:144-145) describe a focus groups as a process involving more than one participant and where the researcher explores a topic to help uncover the participants' views. The authors further state that this method (also called a topical approach) allows for participants' perspective on a topic of interest to unfold as well as a wider variety of information to be shared than in the case of fewer participants.

Subsequent to the pilot focus group interview (FG1), three focus group interviews were conducted with three participants in each focus group. FG2 was done in the board room of a hospital, which was centrally located and easily accessible for participants. Three participants (all three ward managers) attended the focus group, which was facilitated by the nursing academic who was skilled in group dynamics. Due to unforeseen circumstances, the researcher initiated this FG interview until the facilitator arrived. The researcher then acted as an observer. The interview was conducted in a relaxed atmosphere and participants shared their views freely. The discussion lasted approximately 93 minutes and was concluded with refreshments.

FG3 was conducted in the board room of another hospital venue, which was accessible for other participants. It was attended by one HoNS, one deputy and one ward manager and lasted approximately 84 minutes.
The fourth FG was conducted at another hospital venue where three deputies from that hospital participated in the focus group discussion. The researcher facilitated FG3 and FG4.

Being aware of the potential conflict of interest as well as researcher bias, a second skilled facilitator was invited to act as observer and take notes during the FG3 and

FG4 interviews. The observer's task was to observe and take careful notes during the interviews, which was then discussed immediately after the interviews. It was also discussed with the study supervisor. The discussion lasted approximately 74 minutes and concluded with refreshments.

3.10.2 Face-to-face interview with DNS

A face-to-face discussion was conducted with a participant from the DNS in a private meeting room at a pre-arranged venue. Informed consent and permission to record the proceedings was obtained. The interview lasted 43:22 minutes. The researcher made short notes to capture his own thoughts as well as from the participant's observations. The recording was transcribed verbatim after the interview and the notes were added in the margins to ensure completion of data.

3.10.3 Telephonic interview with AHASA

A telephonic discussion was conducted with a participant from the AHASA on a pre-arranged date and time. Informed consent and permission to record the interview was obtained, which lasted 60:22 minutes. The researcher made notes during the interview to capture own thoughts as well as noting the voice cues of the participant. After conclusion of the interview, the recording was transcribed verbatim and notes were added in the margins to ensure completeness of data.

3.11 DATA ANALYSIS

Data analysis involves separating the data into manageable themes, trends, patterns and relationships in order to understand and interpret it.

All the discussions were audio taped and transcribed verbatim. Data was then analysed using the Framework Approach, which involves and describes the systematic and explicit application of the principles of qualitative analysis as a sequence of interconnected stages guiding the analytical process.

This sequence of interconnected stages allows the researcher to move between and across the data until a coherent story emerges, leading to a constant refinement of the themes.

The Framework Approach places great emphasis on the development and use of a matrix, because of the complexity and volume involved in qualitative data analysis (Smith & Firth, 2011:55-56). An extract of the matrix that was developed, based on the findings of this research, is attached as Appendix 8. Use of the Framework Approach on makes the researcher's interpretations of participants' experiences transparent, and illustrates the link between the various stages of the analysis (Ritchie & Lewis in Smith & Firth, 2011:3-4). The Framework Approach of data analysis has four stages:

- *Becoming familiar with the data,* which involves repeated reviewing to become familiar with the data
- *Identifying initial themes and categories* or sub-themes, in which key phrases are identified and developed into codes that are then grouped under initial categories or sub-themes
- *Developing a data coding system,* referring to the creation of a structured outline in which initial categories or sub-themes are linked to initial themes
- *Developing descriptive and explanatory accounts* whereby participants' descriptions are coded and then showing how these descriptions are linked to, and between, codes, categories and themes (Smith & Firth, 2011:5-6, 10-12).

The researcher obtained the assistance of a nursing researcher with a PhD who was skilled in electronic data analysis to assist with the process. Through the application of the steps, as outlined in the Framework Approach, the data was analysed using Atlas ti. computer software as well as manual analysis.

3.11.1 Familiarisation with the data

Becoming familiar with the data involves repeated reviewing and thereby immersing oneself within the data to gain detailed insights of the phenomena being studied (Smith & Firth, 2011:3). The researcher familiarised himself with the data by repeatedly listening to the audio recordings and reading and re-reading the transcripts. Field notes and observations recorded during data gathering were also revisited to obtain a complete picture of the data. This process of re-reading the transcripts and referring to the audio tapes when necessary continued throughout the data analysis process.

3.11.2 Identifying initial themes and sub-themes

This refers to the identification of initial phrases or paragraphs in the transcripts, which are coded. (Smith & Firth, 2011:5). Codes were arranged and re-arranged under initial sub-themes. As more and more codes were identified and the number of sub-themes developed, they were re-arranged into broader sub-themes. Similar sub-themes were eventually grouped together to form initial themes.

3.11.3 Developing a coding matrix

A coding matrix refers to the creation of a structured outline in which initial categories or sub-themes are linked to initial themes. These sub-themes and themes form a coding system (Smith & Firth, 2011:5). A coding system was developed and it was constantly refined throughout the data analysis process as new insights emerged. The coding matrix that was developed for this research is attached as Appendix 8.

3.11.4 Developing descriptive and explanatory accounts

This process entails summarising and synthesising of the coded data by refining initial sub-themes and themes. This is described as a crucial element in qualitative analysis because of the critical thinking that occurs in relation to how participants' descriptions are coded and how these descriptions are linked to, and between, codes, sub-themes and themes. Remaining true to participants' descriptions is said to be a fundamental principle within the Framework Approach (Smith & Firth, 2011:6).

The researcher refined the initial sub-themes and themes until a comprehensive representation of the data emerged, while remaining true to the participants' shared views. This was done by constant reference to the transcriptions, and checking meaning across transcriptions.

3.12 PILOT STUDY

A pilot study is a preliminary study on a small scale to determine the meaningfulness and acceptability of the data collection approach and it is guided by the semi-structured questions.

The pilot study was done at one of the eight selected district hospitals. The chosen participant at the initially selected pilot site did not reply to e-mails and was

unreachable via telephone despite various attempts to make e-mail and telephonic contact. The facilitator subsequently set up the pilot interview with the nurse manager and two deputies of the hospital who indicated their readiness to participate. After obtaining permission, telephonic contact was made with these three participants and the purpose, ethical considerations that would be applied, and the nature and conditions for participation in the study were explained. The participants were also informed that the discussion would be conducted by a nursing academic from the university to reduce researcher bias. The consent form was sent to the participants via e-mail. An appointment, and arrangements, to conduct the pilot study at the hospital were made for the following week.

The researcher and interviewer arrived an hour ahead of the appointed time to prepare the venue. The focus group interview was done in the HoNS office and constituted focus group 1 (FG1). It was an opportunity to test the discussion guide questions for possible errors, to clarify ambiguous questions, and to ensure that participants had a common understanding of the terms used in the data discussion guide (Du Plooy-Cilliers, Davis and Bezuidenhout, 2014:257).

The facilitator facilitated the discussion in the NM's office that lasted approximately 90 minutes. The researcher acted as an observer and made notes during the discussion. The researcher had been mentored and upskilled in group facilitation by the facilitator. Participants were informed that the data would be included in the study findings. The researcher and interviewer agreed that the questions were clear, unambiguous and therefore no changes were made to the discussion guide. Refreshments were served on completion of the discussion.

3.13 TRUSTWORTHINESS

Botma, Greeff, Mulaudzi and Wright (2010:292) cites Lincoln and Guba (1985:218) whom state that rigour, or trustworthiness, is established by subjecting a proposal to the following four criteria: *truth value or credibility, applicability, consistency, and neutrality*.

3.13.1 CREDIBILITY

Credibility refers to the degree of accuracy with which the researcher reports the research findings (Botma, Greeff, Mulaudzi and Wright, 2010:233, 292).

Credibility was assured by initially using an experienced, independent nursing academic, who was skilled in group dynamics, to facilitate the focus group discussions. The facilitator strived to support participants to unpack their views and experiences and to collectively extract meaning from the discussions. The facilitator also limited the potential conflict of interest and served as a mentor for the researcher in conducting meaningful discussions. Furthermore, data analysis was explicitly described to further enhance credibility of the findings (Smith & Firth, 2011:2).

Credibility was further enhanced through triangulation, which is the use of various methods to collect data from different sources (Brink, van der Walt & van Rensburg, 2012:128, 172). Focus groups, face-to-face, and telephonic discussions were used as methods to obtain the views of nurse managers. In addition, a DNS and an AHASA representative were included as additional sources in the data collection process. However, due to the difficulties experienced in convening the focus groups, the independent facilitator became unavailable to facilitate subsequent focus groups (FG3 and FG4) and the researcher facilitated the focus groups. Consultation with the previous facilitator and study supervisor was done to review the content of the focus groups to further ensure credibility and to reduce researcher bias.

The study supervisor and facilitator were supportive throughout this process by being sounding boards and acting in an advisory capacity.

3.13. 2 APPLICABILITY

Applicability is defined as the extent to which the study findings can be generalised to other settings (Botma, Greeff, Mulaudzi & Wright, 2010:233). A rich, detailed description of the data would enable readers to transfer information to other settings and to determine for themselves whether the findings can be relevant (Erlandson et al. in Creswell, 2013:252).

3.13.3 NEUTRALITY

Neutrality refers to the degree to which the findings of the research are free from bias, motives or perspectives (Botma, Greeff, Mulaudzi & Wright, 2010:233).

The researcher commented on his position as a practicing nurse manager who had daily interaction with agency nurses, nursing agencies and fellow nurse managers, which could influence the interpretation and approach to this study (Creswell, 2013:251).

Thus, neutrality was ensured (i) by making notes in a research diary, (ii) keeping a trail of all data sources, data collection methods, experiences, assumptions, decisions made and meanings deduced, and (iii) through careful reflection of the researcher's influence on the research process by unpacking and giving account during discussions on, and during, the preliminary analysis with the supervisor.

3.13.4 CONSISTENCY

Consistency considers whether the findings will be consistent if the study were to be replicated with the same participants in a similar setting. Although literature asserts that qualitative studies cannot be replicated because the real world changes, the following steps have been taken to ensure consistency: (i) keeping record of detailed descriptions of data collection and analysis in a well-organised and retrievable form, and (ii) keeping an accurate description of the research methodology (Botma, Greeff, Mulaudzi and Wright, 2010:233; Marshall & Rossman, 2011:254). This was verified by the study supervisor and the researcher.

3.14 ETHICAL CONSIDERATIONS

The fundamental ethical challenge of all research is to avoid the risk of exploitation of research participants for the benefit of others. Thus, the primary purpose of research guidelines is to minimise the possibility of exploitation in clinical research and, as a result, minimise the possibility of participant exploitation (Emanuel, Wendler & Grady, 2008:125).

3.14.1 Authority to conduct research

The proposal for this study was reviewed and approved by the Health Research Ethics Committee (HREC) of Stellenbosch University (attached as Appendix 1-HREC Reference: S18/08/174). Permission was also obtained from the WCGH who granted approval for the research to be conducted at the eight Cape Metropole district hospitals attached as Appendix 2 (WCGH Reference: WC_201810_030).

3.14.2 The Eight Ethical Principles

The ethical framework for this research were the eight ethical principles that guided the ethical review and conduct of this study. The eight principles are: collaborative partnership, social value, scientific validity, fair participant selection, favourable risk/benefit ratio, independent review, adequate, informed consent, and ongoing respect for participants. Although this framework is extensively used by health research ethics committees to review research protocols, it remains a meaningful guidance for reflection on ethical considerations for a study.

Each principle is accompanied by benchmarks explaining the principle and serving as practical interpretations of what is required to fulfil each principle (Emanuel, Wendler & Grady, 2008:125). The principles and related benchmarks are illustrated in table 3.2.

Table 3.2: Eight principles of ethical research and related benchmarks (Emanuel, Wendler & Grady, 2008:125-131).

Eight principles of ethical research	Description of benchmark
1. Collaborative partnership	Seeks agreement to, and collaboration from, the community where the study is conducted and helps to ensure that the community determines for itself whether the study is acceptable and responsive to their needs
2. Social value	The study findings must have potential value for beneficiaries. Mechanisms must be in place to give effect to the value and it must contribute positively to the current situation
3. Scientific validity	A sound research methodology, generation of useful results, realisation of study objectives without infringing on participants' access to existing services, and be feasibility
4. Fair participant selection	Research objectives must be the primary basis for eligibility: minimal risk to participants, selection of participants to enhance the social value of the study, potential benefits to the participants, and valid reasons for the selection of participants
5. Favourable risk to benefit ratio	Identify, delineate and minimise risk, identify the probability, type and magnitude of appropriate benefits directly related to the study, and determine the risk versus benefits to participants
6. Independent review	Adherence to legal requirements, unbiased independent review panels, transparency in the reasoning of the review panel, and

	assessment based on ethical & scientific considerations reviewers must be competently and independently implemented
7. Adequate informed consent	Consistency in recruitment procedures and incentives: disclosure must be sensitive to participants' contexts, sensitive, complete, obtained with appropriate consent, using acceptable consent procedures and freedom to exit the study
8. Ongoing respect for participants	Monitor the health and well-being of participants, protect confidentiality, permit a change of mind, inform participants of changing results during the study, and care for participants after completion of the study

3.14.3 Application of the Eight Ethical Principles

3.14.3.1 Collaborative partnership

NMs formed the community of interest on which this study focused. The researcher is a currently practicing NM at a general specialist WCGH hospital and was known to some participants. The researcher participated in the first two focus group discussions as an observer while being mentored by the facilitator of the discussions and facilitated the subsequent two discussions.

Participants were contacted individually via telephone and e-mail to inform them of the research. Their initial agreement to participate implied that the research was acceptable because it addressed an important component of their duties. By virtue of their agreement to participate, nurse managers, the DNS and AHASA became partners to this study.

3.14.3.2 Social value

The study findings met all the benchmark criteria in order to create social value for agency nurses, nursing agencies and the WCGH in general, and nurse managers in particular..

The potential value for the participants was that the research findings can provide valuable insight and suggestions supporting nurse managers' efforts to improve the utilisation of agency nurses and to ensure quality nursing care (Emanuel, Wendler & Grady, 2008:125-131).

3.14.3.3 Scientific validity

In order to meet the principle of scientific validity, scholarly practices were diligently applied. Formal departmental approval was obtained to conduct this research. The approval indicated that the study was feasible and that the research methodology was acceptable.

In addition, the data analysis produced useful findings because it provided valuable insight and suggestions useful to agencies, agency nurses and nurse managers. Furthermore, the data analysis indicated that the study objectives had been reached. Thus, all four benchmark criteria were met in order to ensure the scientific validity of this research. (Emanuel, Wendler & Grady, 2008:125-131).

3.14.3.4 Fair participant selection

Four benchmark requirements had to be fulfilled in order to meet this criterion for fair participant selection. Participants were selected as follows:

- The research objectives guided the selection of participants because, through purposive sampling, the researcher had to identify participants who could best answer the research question
- Risk to participants: the study posed minimal risk because participants were only sharing their views on practices relating to the utilisation of agency nurses at their hospitals. Risk was reduced by requesting that the focus group interviews be kept private and confidential
- The social value benchmarks have been met in section 3.12.3.2 above
- Benefits and participant selection: participants were selected for the sole reason that they had the expert knowledge and experience required to best answer the research question. The benefits of their participation was limited to their work environment. No financial benefit was derived from their participation in the study apart from reimbursement for refreshments and participants' travel expenses (Emanuel, Wendler & Grady, 2008:125-131).

3.14.3.5 Favourable risk to benefit ratio

Risk has been identified and addressed in **3.10.** In addition, although absolute anonymity is not possible, participants' identities were protected by referring to participants by means of a code, e.g. P1 to represent Participant 1 so that no

information could be linked to any participant. Therefore, the study posed minimal risk for participants.

Benefits were related to the work environment where participants, as nurse managers, could gain information, guidance and support to improve the utilisation of agency nurses. Through their participation in the study, nurse managers could get valuable insight towards the development of directives and formalising on-the-ground management practices to manage perceived lack of required competencies, increased patients' complaints, poor attitudes and quality of care issues related to agency nurses.

3.14.3.6 Independent review

The principle of independent review is built into many stages of a research project's life. In the first instance, all research protocols need to conform to strict guidelines and principles to receive ethics approval. The HREC of Stellenbosch University approved the protocol for this study and is the body that will conduct an independent review on the ethics of this study.

3.14.3.7 Adequate informed consent

Participants have been briefed individually to determine their willingness to participate in, and be available for, the focus group interviews.

A detailed Participant Information Leaflet (PIL) explaining that participation was voluntary, identities would be protected, and anybody could withdraw from the study at any time followed this. The PIL also contained information on the nature, purpose and process of the study and mentioned that the study posed minimal risk. Those who agreed to participate had to sign consent forms, which served as proof that their participation in this research was voluntary (attached as Appendix 3).

3.14.3.8 Ongoing respect for participants

As this research posed a minimum risk to participants, the researcher took care of the participants' well-being by ensuring reasonable anonymity through assigning numerical codes to participants' quotes in the text.

Furthermore, participants were assured that the data would be protected in line with the ethics approval of this research.

Data management ensured that all audio recordings, transcripts, signed consent forms and field notes would be stored at the university for at least five years and that access to the data was restricted only to the researcher, study supervisor and the two facilitators.

Finally, demonstrating ongoing respect for participants implied that the researcher would provide feedback to all participants once the research has been approved and accepted by the university. This was also a requirement by the WCGH and the researcher is ethically bound to abide by this requirement.

3.15 CHAPTER SUMMARY

The aim of this chapter was to provide a detailed discussion on the research methodology applied to this study. It describes the study setting, research design and population and sampling. The process of data collection, data analysis and trustworthiness is also described in detail.

The findings of the research study are presented in Chapter 4.

CHAPTER 4
FINDINGS

4.1 INTRODUCTION

Chapter 3 described the research design and methodology that was used for this study. It described the aim and objectives, study setting, population and sampling, pilot interview, data collection, data analysis, rigour in qualitative research, and ethical considerations.

In Chapter 4 the findings of this study are examined, discussed, and presented according to the themes and sub-themes that emerged from the data collection and analysis. The data was collected through four focus group interviews, one face-to-face interview and one telephonic interview using semi-structured interview questionnaires. The audio recordings were transcribed verbatim and analysed in line with the four stages of the Framework Approach. The findings are presented according to the study objectives and categorised according to the sub-sections of the interview questionnaires. The data is presented in three sections. Section A describes the sample realisation process including the demographic data of the participants. Section B describes the data analysis process, themes and sub-themes, which emerged. In Section C an interpretation and discussion of the findings are presented.

4.2 SECTION A: BIOGRAPHICAL DATA

The researcher facilitated a relaxed atmosphere and eased in questions such as age, position and years of nursing experience. Their responses were noted.

4.2.1 Demographics of participants

A total of 14 participants participated in this study, i.e., four focus group interviews consisting of three participants each (including participants of the pilot study), one face-to-face interview and one telephonic interview. All participants were nursing professionals and comprised of 12 nurse managers from the hospitals, a nursing participant representing the DNS, and an AHASA participant, who in his capacity as a

nursing professional is also the agency manager. The hospital nurse managers comprised of two HoNS, seven deputies and three ward managers.

4.2.2 Gender and age distribution

Twelve participants were female and two were males. Nursing is known as a female-dominated profession and this was reflected in the predominantly female composition of the participants. The age ranges were between 40 and 65 years. Three participants were between 40 and 49 years of age, the majority of participants (n=8) were between 50 and 59 years and three were between 60 and 65 years.

4.2.3 Years of experience post-qualification

The 12 hospital participants reported a collective 130 years' experience in their present ranks. However, this does not reflect their total years within the nursing profession. The DNS participant had been at the provincial head office for the past 11 years. The AHASA participant had been a nursing agency manager for 11 years.

4.3 SECTION B: DATA ANALYSIS PROCESS

Data analysis involves the separation of data into manageable themes, trends, patterns and relationships in order to understand and interpret it.

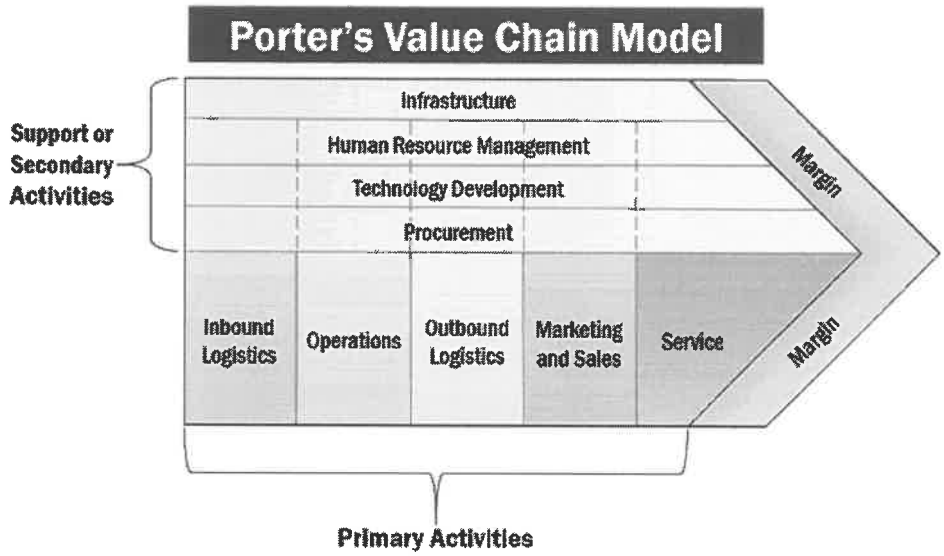
Data from the focus group discussions and interviews were audio taped and transcribed. Key phrases were identified and developed into codes and then linked to initial sub-themes and themes, using the Framework Approach for the thematic analysis of semi-structured interview transcripts as discussed in Chapter 3 (Ritchie & Lewis in Smith & Firth, 2011:3-4; Gale, Health, Cameron, et al., 2013: 2). As more codes and sub-themes emerged, the initial codes, sub-themes, and themes were further analysed and categorised.

The themes were aligned with Porter's Value Chain Model (PVCM), which forms the conceptual framework for this study. District hospitals deliver healthcare services to its surrounding populations and nurses form part of the myriad of hospital employees involved in the delivery of such healthcare services. WCGH hospitals rely on nursing agency suppliers for agency nurses to assist with the rendering of health services.

This supply chain management (SCM) action is a transfer of a required service from one supplier (e.g. a nursing agency) to another (in this case, district hospitals). The value chain, however, refers to the value that is added along the entire transfer process.

A key factor of value chains are the activities and players involved in delivering the services that provide customer value, because they present the critical relationships that enable the flow of goods and services between the various players who ultimately define the quality of services and how it will be paid for (Montgomery & Oladapo, 2014:174, 176). Albarune, Farhat and Afzal (2015:39) support this fact in their statement that healthcare managers strive to improve operational efficiency in order to positively influence cost structures, patient satisfaction and quality of care. For the purpose of this study, the players were the WCGH (nurse managers, administrative-, human resources- and supply chain staff) and agencies (agency managers, agency nurses and their administrative support staff).

Porter's Value Chain Model (Horne, 2013:660).



Thus, a value chain is a subsection of the supply chain and it involves engaging in many activities to create value. PVCM categorises these activities into primary- and secondary activities (McGee, 2014:1, 2).

The primary activities are: (i) *Inbound logistics*, which refer to the procurement of resources before the services can be delivered, *(ii) operations* refer to how the

resources are produced, (iii) *outbound logistics* refer to the delivery of a service once it is ready, *(iv) marketing and sales* entail how the service is presented to the customers. *Services* refer to the support provided to the customer (McGee, 2014:1).
Secondary activities include: *(i) firm infrastructure* refers to all management, financial & legal systems in place to make business decisions & effectively manage resources, *(ii) Human Resource Management* involves all processes & systems involved to manage employees & hire staff, (iii) *technology development* refers to equipment, hard- and software and technical skills required to assist in the creation of value and innovation, and (iv) p*rocurement, which* refers to the sourcing and delivery of goods and services (McGee, 2014:1, 2).

Most of the themes identified in this study can be linked to the key elements of a hospital's value chain, thus the primary activities have been modified to fit in with a service delivery organisation such as the WCGH district hospitals to highlight areas where value may be enhanced with the utilisation of agency nurses. This is illustrated in the table below. The linkages were highlighted within the findings.

Table 4.1: Modified PVCM primary activities for district hospitals

MODIFIED PVCM PRIMARY ACTIVITIES FOR DISTRICT HOSPITALS				
Sourcing	**Placement**	**Productivity**	**Cost**	**Processing**
Identify activities and improve the sourcing process and time-saving measures	Enact placement according to the competencies of the agency nurse and the health care needs to be met	Identify gaps in, and implement improved supervisory oversight	Analyse direct- and indirect costs for improved decision-making	Evaluate all activities for quality of care and affordability relating to output of agency nurses

4.2.1 Codes and clusters

Coding involves applying a label (code) to sections of the data that the researcher deems relevant or important to the study aim and objectives and it aims at categorising all data so that it can be compared systematically to other sections of data (Gale, Heath, Cameron, et al., 2013: 4).

Data from the focus group, face-to-face, and telephonic interviews, were coded and re-coded for relevance to the study, but also to identify that which may be unexpected or invisible, because it may not be clearly expressed, and to explain such anomalies (Gale, Heath, Cameron, et al., 2013: 4). Three unanticipated themes emerged from the data and are included in the presentation of the findings.

Coding is an important step in the data analysis process since codes form the "smaller meaning units" from which themes and categories (or sub-themes) are derived (Braun, Clarke, Hayfield & Terry, 2018:3). The coded data was further grouped into clusters around similar and interrelated ideas to create categories or sub-themes that were linked to the themes (Gale, Heath, Cameron, et al., 2013: 1).

4.2.2 Themes and categories or sub-themes

A theme is an interpretive concept describing aspects of the data and forming the final product or analysis output of the entire dataset. The development of themes involves the systematic search for patterns to create full descriptions capable of highlighting the phenomenon under investigation (Gale, Health, Cameron, et al., 2013: 2, 3).

Data collected through focus groups, a face-to-face and a telephonic interview was coded and re-coded. The coding process produced 10 themes reflecting the views of participants, based on the study aim and objectives. Organising codes into categories or sub-themes is very helpful in managing, organising and summarizing a large volume of data in a way that supports answering the research question (Gale, Heath, Cameron, et al., 2013:1).

4.4 SECTION C: THEMES EMERGING FROM THE INTERVIEWS

In the discussion and presentation of the themes emerging from the data, the four focus group interviews were labelled FG1 to FG4 in the sequence in which they were conducted. Each focus group had three participants and, therefore, participants were identified as P1, P2 and P3 in order to link quotes to specific participants. The individual face-to-face and telephonic interviews with the DNS and AHASA had one participant each and were labelled DNS1 and AHASA1 respectively. All transcripts were consolidated into one document with sequential page numbering. For ease of reference, the focus group, participant and the page number where a participant's quote appears in the transcript are presented as follows: e.g., FG1, P2, pg. 6 (Focus

Group 1, participant 2, page 6) . Reference to specific provinces made by participants have been replaced by alpha-numerals X and Y. The themes and sub-themes emerging from the data are presented in Table 4.3.

Table 4.2: Themes and sub-themes

Themes	Sub-themes
1. Sourcing of agency nurses (4.4.1)	1.1 Sourcing process
	1.2 Using the NIMS
	1.3 Additional benefit of NIMS for NMs
	1.4 Sessional (overtime) recruitment
	1.5 System challenges
	1.6 Dealing with booked nurses not required anymore
2. Placement of agency nurses (4.4.2)	2.1 Service area requirements
	2.2 Competencies
3. Supervision (of agency nurses 4.4.3)	3.1 Challenges with supervision
4. Requirements to practice as an agency nurse (4.4.4)	4.1 SANC registration
	4.2 Verification checks
	4.3 Competency testing
5. Deficits in agency nurse utilisation (4.4.5)	5.1 Dealing with non-performance
	5.2 Ensuring safe practices
6. Ensuring quality of care (4.4.6)	6.1 Orientation
	6.2 Checking knowledge and skills
	6.3 Conducting spot-checks
	6.4 Evidence of quality nursing care
7. Budgetary monitoring (4.4.7)	7.1 Agency budget allocation
	7.2 Monitoring
	7.3 Avoiding overspending
8. Caring attitude towards agency nurses (4.4.8)	8.1 Hospitals
	8.2 Agencies
9. Reported disconcerting agency practices (4.4.9)	9.1 Reported agencies' conduct
	9.2 Reported agency nurses' conduct
10. Agency nurses from other provinces (4.4.10)	
11. Participants' recommendations (4.4.11)	11.1 Recommended actions for hospitals
	11.2 Recommended actions for agencies
	11.3 Other recommendations

Theme 1: Sourcing of agency nurses (4.4.1)

Sourcing, in the context of this study, refers to the process of requesting, selecting and approving agency nurses to do shift work in hospitals based on the required skills

needed to deliver patient care. Six sub-themes emerged from the discussion about sourcing agency nurses and are summarised in Table 4.4.

Table 4.3: Theme 1: Sourcing process: sub-themes and clusters

Sub-themes	Clusters
Sourcing process	Based on need
	Routine practices
Using the NIMS	NIMS compliance
	Actual implementation of NIMS
	Reasons for alternative implementation
Additional benefit of NIMS for NMs	Unanticipated insight
Sessional (overtime) recruitment	Preference of overtime vs. agency
Systemic challenges	
Dealing with unrequired booked nurses	

Sub-theme 1.1: Sourcing process

The sourcing process of agency nurses refers to the prescribed manner in which hospitals are required to place their requests for agency nurses. Participants indicated that it was based on the requirements of wards and that they had routine practices for the sourcing of agency nurses.

Cluster 1.1.1: Based on need

Participants agreed that the sourcing of agency nurses was based on the need for additional nursing resources and stated that

> *"…you request extra staff which you need. Like for instance for this ward you need a sister or EN"" (FG 1, P2, pg. 1).*
>
> *"…during your planning, you will then…project for the amount of agency people that you will need" (FG3, P2, pg. 42).*
>
> *"…we phone them and ask…we need a nursing assistant or we need, need a sister" (FG4; P1, pg. 59).*

Cluster 1.1.2: Routine practices

Routine practices refer to the general procedures hospitals use to source agency nurses. It emerged from the data that hospitals had two ways in which they sourced these nurses, through an electronic procurement system and by direct calling as reflected in the following quotes:

> *"Okay we have this system called NIMS, which is Nursing Information Management System. This is a system where we have uh electronically requesting nurses on the system" (FG3, P1, pg. 42).*
>
> [We procure nurses] *"By using NIMS, the NIMS request system and also by directly phoning the different agencies" (FG4, P3, pg. 59).*

Knowledge about the routine practices are important because the WCGH has contractual arrangements with various nursing agencies in which the procurement process for health facilities are prescribed. Thus, certain routine practices may have contract management implications as it may occur outside of the contractual stipulations.

Sub-theme 1.2: Using the NIMS

The NIMS is an electronic procurement and agency information management system that all district hospitals in the Cape Metropole use to request the nursing categories and skills required from the WCGH-accredited nursing agencies, which they supply.

Cluster 1.2.1: NIMS compliance

It has emerged from the data that all participant hospitals make use of the NIMS as stated by one participant:

> *"…two weeks before the changeover, you go into the system… you put it on the system and then it goes to all the, to ten agencies" (FG1, P2, pg. 1).*

The DNS participant confirmed this compliance as evidenced in the following quote:

> *"…you give that agency a request and that request must be a signed off request, an approved request…your managerial processes must be in place. Your administrative process will be the information management…" (DNS, pg. 79).*

Cluster 1.2.2: Actual implementation of NIMS

The data revealed that the hospitals used both the NIMS as well as telephone calls to request nurses for agency work. The results also reflected that, although telephonic requests were not the acceptable norm, participants often used this means of communication to request agency nurses.

> *" ja it's the NIMS system or we even phone the nurses, the agency nurses ourselves" (FG1, P1, pg. 2).*

> *"...there is deviation from the system where we drew verbal or telephonic requests as well." (FG2, P2, pg. 23).*

> *"...we* [are] *entering then a fraudulent action because you not supposed to phone and make contact and say who I want" (DNS, pg. 80).*

This finding is surprising, because it emerged that district hospitals routinely made telephonic requests directly to both agencies and agency nurses. It also appeared that there was an awareness that this action might not be acceptable in terms of the contract.

Cluster 1.2.3: Reasons for alternative implementation

Participants revealed various reasons for contacting agencies and agency nurses directly. It was their view that telephone calls related to the time pressures they experienced when permanent staff would report on short notice that they would not be on duty. One participant also expressed a view that agencies appeared not to attend to electronic requests before a certain time in the morning.

> *"...depending on the timeframes...If we need them like in seven o clock tonight and its six-o clock already and we have the names and the telephone numbers of specific agency nurses, we will just phone them ourselves" (FG1, P1, pg. 2).*

> *"...the reason why we phone is because...nobody is manning that computer system (at the agencies) in the morning until about 8 o clock" (FG4, P2, pg.60).*

"...if people suddenly phone in sick they're not coming in" (FG4, P3, pg. 60).

These were perceived to be convincing reasons for circumventing the NIMS when nurse managers needed to source agency staff.

Sub-theme 1.3: Additional benefits of NIMS for NMs

The face-to-face interview with the DNS participant revealed surprising insights regarding the NIMS capabilities and functionality.

> *"The NIMS, your NIMS information system is not just* [for use by the] *agency. We also have the NIMS system now, where at institutional level...it will reflect if one of our nurses works for the agency...Because it would reflect our leave, it would reflect our sick days etc." (DNS, pg.80).*

The researcher was not aware of whether this information was known to NIMS clerks and nurse managers, but it will be addressed as a recommendation.

Sub-theme 1.4: Sessional (overtime) recruitment

Overtime is a process whereby permanent staff is scheduled to work extra shifts additionally to their 40-hour work week. This form of staff scheduling is available to nurse managers as an adjunct to agency nurses and it is another way to ensure that sufficient nurses are on duty for each shift.

Overtime rates are calculated according to a nurse's personal salary earnings, and anecdotal evidence suggested that it was generally costlier to the employer than agency rates for a similar nursing category.

The data revealed that some nurse managers selected to give preference to permanent staff before sourcing nurses through the agencies when there was a need for more nurses. Two nurse managers stated that:

> *"...die nurses...wat in die system* [verpleegpersoneel wie voltyds in diens van die Wes-Kaapse Regering: Gesondheid] *is, kry eerste option" [the nurses in the system* {nurses who are in fulltime employment with the WCGH} *get first option] (FG1, P2, pg. 12).*

> *"…we firstly start with head of nursing* [when requesting staff to work] *overtime, when somebody's absent we don't go straight to the agency…We firstly* [use] *overtime…" (FG3, P1, pg. 49).*

It also emerged from the data that some nurse managers circumvented certain nursing agencies. One nurse manager stated the following:

> *"There are certain agencies that I do not phone because, number one, they promise us staff that never pitch up…and there are the three or four agencies that will potentially* [deliver]*…and so you phone them because I do not have time to phone all six or seven agencies, especially knowing three of them either don't give us staff, or they give us names…*[of which the nurses] *don't pitch up, or the other one is that the staff do pitch up, but they are wholly unsuitable for what we're requesting…" (FG4, P2, pg. 60).*

Sub-theme 1.5: Systemic challenges

System challenges, in the context of this study, refer to the general challenges experienced by the participants with the use of the NIMS. It could be of importance to identify these challenges as expressed by participants because it may be an important factor to consider when the findings are reported to the WCGH.

Several participants expressed feelings of frustration and reported that, in their opinion, the sourcing of agency nurses is problematic and that the NIMS seemingly is not functioning well.

> *"…that is my frustration with the NIMS system because it causes a lot of uhm, how can I say, constraints to get the body into your ward" (FG2, P2, pg. 24).*
>
> *"We've put it* [the request for agency staff] *on NIMS I think three, four times:* [yet] *we don't get anything. But we have got all these agencies. They don't have anyone that is* [available] *…* [this is] *what our biggest problem is" (FG1, P3, pg. 4).*
>
> *"…it doesn't function well because…you put your request on NIMS you must wait for it,* [for] *an hour or two so…* [it is] *not actually functioning well, because you wait too long to…get that staff…" (FG3, P1, pg. 42).*

Sub-theme 1.6: Dealing with booked nurses not required anymore

An unrequired, booked nurse means that an agency nurse may have been scheduled to work, either by a hospital or an agency. However, it may happen that the nurse may no longer be required by the time they report for duty, and this situation needs to be managed, because it has financial implications for both hospitals and agencies.

The participants described that they dealt with unrequired, booked nurses in various ways. Nurse managers considered other departments in their hospitals first that may need extra nurses and they would, therefore, make enquiries to place the nurse elsewhere. In the words of one nurse manager:

> *"…first see if there's maybe a one of the other departments* [that would need the booked nurse] we *phone around and find out if maybe there's a ward with a challenge in terms of staffing, and if they can accommodate the person" (FG3, P2, pg. 44).*

Cancelling the booking with the agency and sending the nurse home was another practice among participants who agreed that cancelling the nurse's shift with the agency was important, because the hospital had to pay a cancellation fee that was cheaper than allowing the unrequired nurse to work an entire shift.

> *"…they charge you with a cancellation fee…cancellation fees is cheaper than keeping the person…" (FG3, P1, pg.44).*

Two participants described other ways in which they dealt with the matter: allowing the agency to resolve the matter and letting the nurse work a half-day instead of a full-day shift.

> *"…unless the agency made a mistake and they often…will send two people…so then we leave it,* [and tell them] *there's a telephone, phone your agency, I* [can] *only use one of you, sort it out. So we tell the agencies they must sort it out" (FG4, P2, pg. 61).*

> *"…sometimes…*[we] *try to let the person work a half day, instead of having to pay [their] cancellation" (FG3, P3, pg.44).*

Theme 2: Placement of agency nurses (4.4.2)

Placement refers to the common practices implemented in district hospitals to deploy agency nurses who report for duty. It emerged from the data that participants

considered two factors, i.e., service area requirements and the agency nurse's competencies when deciding to place them.

It appeared that these were important factors to ensure quality nursing care. However, participants reflected certain challenges that they experienced with the placement of agency nurses.

Sub-theme 2.1: Service area requirements

It is important to consider service area requirements because they form the basis for deciding the quantity and quality of agency nurses to be sourced. Participants indicated that they specified on the NIMS what they required from an agency nurse when they placed requests. In the words of two participants:

> *"…you ask for a Psych specific, then you asked for somebody who worked previous in a Psych ward to see that you can place that person…" (FG2, P3, pg. 24).*
>
> *"…it should be within the scope of the practice of the nurse, one, and it should not be an unrealistic, unfair request" (AHASA, pg. 87).*

It also emerged from the data that participants often re-allocated agency nurses away from the originally requested service area. The motivation for the deviation from the original booking request appeared to be based on service needed as well as the specific skills of the agency nurse.

> *"…For instance,* [when] *the sister comes,* [and] *we booked the sister for casualty, and that sister knows how to work in high care, we negotiate with the staff that we can move that sister to high care…sometimes…certain agency staff…don't want to be moved. If they are booked in D Ward they don't want to be moved anywhere* [else]*…" (FG1, P3, pg. 8).*

The AHASA participant seemed to agree with this practice.

> *"…You could get away with this maybe in a…public hospital facility….*[she usually works] *in a maternity ward and she's been booked for medical ward* [where she] *could be assisted by maybe two, three other nurses who are there…" (AHASA, pg. 85-86).*

However, the DNS participant expressed an opposing view:

> *"It can be considered* [by the hospital] *as a best practice but it's out of the contract, which we as* [the] *provincial office can't condone…" (DNS, pg. 80).*

The data clearly indicated divergent participant views in relation to the placement of agency nurses when reporting for duty according to the real-time service area needs. It appeared that this practice might have contractual implications and will be addressed in the recommendations section of this study.

Sub-theme 2.2: Competencies

Competencies refer to a nurse's skills to perform nursing tasks and procedures correctly. Participants reflected certain challenges that they experienced with the competencies of agency nurses as follows:

> *"…when you get the people…you realise that this person doesn't know anything or hasn't worked in the department before." (FG1, P3, pg. 5).*
>
> *"…many times we have contacted the agencies to say: sorry please* don't [send] *this person* [again]*…" (FG2, P1, pg. 26).*
>
> *"…one of the things is the HB's* [measuring the blood haemoglobin levels], *they don't know how to do the HB's…If you have somebody that is not up to scratch…then we will then say to the agency staff members…this person is maybe not suitable…" (FG4, P2, pg. 62, 63).*

Theme 3: Supervision of agency nurses (4.4.3)

Supervision refers to the oversight which is provided to monitor agency nurses' productivity, performance, conduct, and the manner in which they execute their clinical skills.

Supervision is an important control measure because it may provide a valuable baseline for reporting the findings on agency nurses while supervising them. In the interest of quality care, patient safety and clinical risk reduction it is important that nurse managers source agency nurses who have the necessary competencies.

Sub-theme 3.1: Challenges with supervision

Participants highlighted certain challenges they experienced with the supervision of agency nurses. One participant emphasised the particular challenge of supervising agency nurses on night duty where there are no operational/ward managers on duty

as is the case on day duty. Instead, wards are generally under the supervision of a shift leader only. The participant stated that:

> *"…if you talk about the direct supervision on the shift, it is difficult… (it's) more difficult on night duty because you have this one assistant nursing manager* [who covers several wards]*… it's impossible to sort of monitor or supervise…" (FG3, P2, pg. 45).*

Two participants also alluded to other measures employed on day duty to supervise agency nurses and stated:

> *"You do spot checks… place her with a permanent nurse… the sister must guide and see whatever she must do…" (FG2, P3, pg. 25)* and

> *"…during the day there is operational manager who is working from seven to four that will be the main supervisor…" (FG3, P1, pg. 44).*

One participant reported that the supervisory function to oversee agency nurses was included in the participant's current staff performance cycle.

> *"…incorporate supervising and mentoring, coaching and you are responsible for the agency nurse as part of your KRA's* [key result areas] *as an Operational Manager" (FG2, P2, pg. 33).*

It was thus the participants' perception that supervision was a challenging management function.

> *"…they* [permanent staff] [are] *complaining every day* [the agency nurses], *because they don't do their work or perhaps they* [the permanent staff] *are delayed because they are busy guiding* [the agency nurses]*…" (FG2, P1, pg. 27).*

Theme 4: Requirements to practice through an agency (4.4.4)

Nurses in South Africa are required by law to be registered with the SANC in order to practice their profession. In addition, the WCGH requires that contracted nursing agencies do qualifications checks, competency tests, as well as verification checks with agency nurses' previous employers before placing them in WCGH facilities. The data revealed that AHASA follows a particular screening process to enrol nurses who

want to work as agency nurses. This entails checking nurses' SANC registration status, qualifications and testing the nurses' competencies as described below.

Sub-theme 4.1: SANC registration

The SANC is the regulatory body for nursing education and practice in SA. In terms of the Nursing Act 33 of 2005 it is a legal requirement that nurses are only allowed to practise their profession if they have current registration with the SANC. It is thus illegal to practice without such registration.

Cluster 4.1.1: Current license to practice

Nursing agencies are the employers of agency nurses and, therefore, have to ensure that their nurses have current SANC registration in order to practice nursing. It is noted that none of the district hospital participants made any reference to agency nurses' current license to practice. It is assumed that all participants accepted that it was the nursing agencies' responsibility to comply with the legal requirement of current SANC registration.

The importance of verifying current SANC registration status becomes more significant in view of a study finding in which the authors explored the characteristics of 106 nursing agencies across SA. Although the study yielded a response rate of 49%, it was reported that only 81% of nursing agencies agreed that they checked SANC registration of nurses (Olojede & Rispel, 2015:76). The authors indicated that none of the participating nursing agencies were affiliated to AHASA because a separate study was conducted among AHASA-affiliated agencies. The DNS participant confirmed that not all WCGH-accredited nursing agencies were affiliated to AHASA.

The AHASA participant confirmed that the organisation's affiliated nursing agencies addressed this aspect when he stated that agencies *"…make sure that your nurses are SANC-compliant. In other words, you need to check…to make sure that that nurse has actually…renewed… before the 31st of December for that year…" (AHASA, pg. 91).*

The data also revealed that the organisation paid attention to the registration status of community service professional nurses to ensure that they were fully licensed to practice as fully-registered professional nurses: *"You make sure that the nurse who is*

a new nurse…she's completed her comserve, to make sure that she has paid what she owes SANC" (AHASA, pg. 91).

The DNS participant also confirmed the importance of agencies verifying their nurses' SANC registration: *"…the regulatory SANC processes that must also be in place." (DNS, pg. 79).*

Sub-theme 4.2: Verification checks

The data revealed the importance AHASA attaches to do verification checks on nurses who wish to do agency work. Verification checks entails confirming an agency nurse-applicant's qualifications, competencies and references. AHASA stated that: *"…you cannot…expect to be registered and you haven't given us…ample time to follow up…on your skills…competency… qualifications…" (AHASA, pg. 91).* AHASA compliance with doing verification checks is a requirement in terms of the contract between agencies and the WCGH. This was confirmed by the DNS participant who stated that: *"It's stipulated in the contract…We must expect that according to the agencies, that verification is being done by them…" (DNS, pg. 79).*

This was in contrast with the study findings by Olojede and Rispel (2015:80) where it was reported that only 82% of nursing agencies not affiliated to AHASA, confirmed that they requested certified copies of nurses' qualifications and only 21% indicated that they conducted reference checks with nurses' past employers. Thus, the aspect of verification checks by nursing agencies may need further attention in view of the fact that the DNS confirmed that not all WCGH-accredited nursing agencies were affiliated to AHASA.

Sub-theme 4.3: Competency testing

Competency testing refers to assessing an agency nurse's knowledge and ability to perform nursing procedures corresponding to their rank and qualifications. It is presented in this section to highlight agencies' responsibility to assess competency.

The data revealed that it is a WCGH contractual requirement that agencies do competency testing. *"…in the contract we put now in that they must now have a clinical nurse co-ordinator that's doing the clinical training…" (DNS, pg. 79).*

The AHASA participant provided valuable insights into the organisation's approach to meeting the contractual obligation to do competency testing as follows:

"…it means that now your competency will be tested… you will then be referred to a clinical facilitator… skills will be tested again to determine in which field we should then place you…" (AHASA, pg. 92).

"…you will get an AHASA test to be written and you need to meet the requirements …The requirement should be at least minimum 70% for you to pass in order for you to…register to an AHASA…agency… (AHASA, pg. 92).

Theme 5: Deficits in agency nurse utilisation (4.4.5)

Deficits in the context of this study refer to insufficiencies, which participants have identified with the utilisation of agency nurses. These have been coded as agency nurses' non-performance and unsafe practices. This section highlights the measures participants have implemented to manage these deficits.

Sub-theme 5.1: Dealing with non-performance

Dealing with non-performance refers to participants' actions to efficiently and effectively manage non-performance of agency nurses. Non-performance may have serious negative consequences, e.g., poor patient and staff health and safety outcomes, quality and medico-legal risks. It is thus essential that every nurse delivers safe, quality care as part of the team who has been assigned to deliver such care.

Cluster 5.1.1: Allocating other responsibilities

Participants expressed dissatisfaction with the performance of some agency nurses and revealed that they sometimes have to allocate alternative responsibilities, e.g. allocating the work of a lower category nurse (enrolled nurse or a nursing assistant) to a professional nurse (sister) who is not performing at the required level.

"…most of the time she keeps on calling the staff nurse …and then…you must ask the …sister [to] do *the staff nurse work because you can't let her do nothing because she's getting paid for that…or you must let her do the nursing assistant's work,…" (FG4, P1, pg. 67).*

Cluster 5.1.2: Terminating the shift and sending nurses home

Terminating a shift and sending an agency nurse home appears to be one of the options exercised by participants when the nurse is no longer needed, or is not

prepared to be re-assigned somewhere else in the hospital. Two participants indicated that, in some instances, it is better to send the person home and rather pay a cancellation fee to the agency: *"…it is better to send that person home…" (FGD3, P2, pg. 44)* and *"We can terminate…a shift…immediately…" (FG1, P1, pg. 10).*

Sub-theme 5.2: Ensuring safe practices

Safe nursing practices refer to the technical skills and other competencies that nurses should have to perform nursing procedures safely and correctly. These skills and other competencies are important to ensure good patient outcomes and to reduce medico-legal risks for the WCGH as well as for all nurses. It emerged from the data that participants managed unsafe practices in various ways, e.g., by requesting the agency to replace the nurse, not booking the nurse for the hospital again and reporting the nurse to the agency and the WCGH.

Cluster 5.2.1: Requesting replacement, non-booking and reporting to the agency

One participant reported that she will not re-book an agency nurse when she was dissatisfied with the nurse's performance.

> *"…we will not book that body again." (FG2, P3, pg. 26).*

The DNS participant stated that participants should report non-performance to both the agency, as well as the WCGH via the NIMS.

> *"…if something happens on…the facility level, that must be…on the NIMS system…The institution communicates with…the agency…" (DNS, pg. 79).*

The data revealed that participants were aware that non-performance needed to be reported and there was evidence of reporting it to the agencies as stated by one participant:

> *"…phone this…agency and tell them…please replace or we put* [the request back] *on* [the] *NIMS* [and] *rebook somebody else" (FG1, P1, pg. 9).* Another participant confirmed reporting to both the agencies and the DNS when she stated that *"…things like that* [obviously] *gets…reported to the agency and then we send an email to* [the DNS]*" (DNS, pg. 63).*

However, there was evidence that not all instances of non-compliance to requests for competent agency nurses had been reported.

Cluster 5.2.2: Leniency in reporting

The data revealed that some participants were reluctant to report instances of non-compliance. The reasons for this were varied and appeared to be a mix between dependency on the much-needed nursing hands, non-clarity on the reporting mechanisms, feeling sorry for the agency nurse and being too busy to report non-performance as evidenced by the following participant statements:

> *"...a report is written. But I think we became so dependent and, how can I say...our nursing culture have become so dependent on this nurse...that we want there that sometimes we...make lee ways" (FG2, P2, pg. 26).*

> *"...they either feel sorry for this person because if we do write a report to the agency this person might never get work somewhere else." (FG1, P1, pg. 10).*

The issue of reporting agency nurses' non-performance may have implications for patient safety, cost and medico-legal risks for both nurses and the WCGH and needs to be addressed.

Theme 6: Ensuring quality of care (4.4.6)

Quality of care is an on-going debate in healthcare circles worldwide. It is accepted that the WCGH district hospitals have quality standards in place. It is also accepted that the WCGH utilise agency nurses in its facilities on a daily basis.

For the purpose of this study it was understood that quality, as related to agency nursing, centred on verification of qualifications, evaluating competencies, and doing orientation before nurses are placed in hospitals. Although it was beyond the scope of this study the researcher considered whether an approved quality standard was available for a comprehensive assessment of agency nurses because it may be of value for healthcare facilities, agency nurses as well as agencies.

Sub-theme 6.1: Orientation

Orientation is generally understood to mean the agencies' responsibility to ensure that agency nurses have received some form of induction to familiarise themselves with the new work environment.

Orientation is important because it provides nurses with an opportunity to meet the permanent staff, get to know the physical lay-out, understand and get to know the routine and important policies of the placement areas where they may be placed. It also affords them an opportunity to do a number of shifts in the wards as a trial run to "practice" in an unfamiliar environment. The AHASA participant phrased it eloquently when he stated that orientation *"...gives the candidate the opportunity to check out the hospital. And then together they decide whether they are good for one other" (AHASA, pg. 93).*

Cluster 6.1.1: Role of the agencies

The AHASA participant emphasised the agencies' role in the orientation process and stated that AHASA agencies place new agency nurses at various hospitals for orientation. Literature indicates that AHASA does an initial agency orientation workshop to test the nurses' skills that would assist the agencies in determining in which discipline or field the nurse can be ideally placed.

> *"...now you've been found competent with the clinical facilitator. She will then take you to a hospital...you will shadow a senior for...*[a] *minimum* [of] *two days,* [a] *maximum* [of] *four days...you would...work under supervision for a couple of days and this gives the hospital the opportunity to check out the candidates (AHASA, pg. 92).*

Following the initial orientation in which she must be found competent, the agency's clinical facilitator will escort the agency nurse to a hospital for further orientation.

Cluster 6.1.2: Role of the hospitals

It is clear from the data that the hospitals engage in the orientation of agency nurses ranging from orientation to the surrounding environment, sharing, teaching and helping them, to "a quick introduction" to the ward routine and the surrounding environment. In the words of one participant:

"…we orientate them from the office down to the last person" (FG2, P3, pg. 38).

Another participant confirmed their involvement in orientation by stating that

"…the sister that's running the ward to orientate them to the layout and to the workings…and the routine of the ward" (FG4, P2, pg. 61).

However, at least one participant acknowledged that it can be challenging to offer proper orientation when a nurse reports for duty by stating that:

"…if a person comes to work, there [is] *no time to work through an orientation program …but at least there are some measures…to ensure that the person at least has some direction…" (FG3, P2, pg. 45).*

Although it was not confirmed that all agencies engaged in placing new agency nurses for a specified number of days at hospitals for orientation, one other participant confirmed that, according to her statement, this was happening with at least one agency. She stated: *"…there was a agency…If you ask for a staff member to work, then they (the agency) say they must at least one day, they must work for free to see if…the work that they* [are] *supposed to give is up to standard …" (FG2, P3, pg. 32).*

Sub-theme 6.2: Checking knowledge and skills

Checking the agency nurse's knowledge and skills entails the agency's verification of the nurse's qualification and testing the person's nursing knowledge and competency to perform nursing procedures and tasks.

Cluster 6.2.1: Hospitals' rapid assessment of competencies

The data revealed that hospitals engage in some form of judging agency nurses' competencies. One participant stated that she was able to screen the nurses' skills on the NIMS after the agencies had submitted the names of those nurses who could be selected and confirmed for placement on the requested shifts:

"…you sit in front of that computer, you check all the years, you check all the [detail loaded]*…" (FG2, P3, pg. 24).*

Another participant confirmed this.

"...the first step of screening should be on the NIMS system...If they are suitable for the job that they are requested..." (FG2, P2, pg. 25).

Cluster 6.2.2: Agencies' assessment of competencies

AHASA affiliated nursing agencies are expected to do competency assessments on new agency nurses. The data revealed that AHASA agencies have clinical facilitators who do the competency assessments.

"...an AHASA test to be written and you need to meet the requirements...at least minimum 70% for you to pass...in order for you to register to an, AHASA...agency (AHASA, pg. 92).

"...You would then be referred to an AHASA...clinical facilitator, who would then take you on a...orientation workshop where your...skills will be tested... the clinical facilitator has her own...way of doing...competency tests..." (AHASA, pg. 92).

Sub-theme 6.3: Conducting spot-checks

A spot-check in the context of this study is an un-announced, informal walk-about for the purpose of visiting agency nurses and managers and to double-check, follow up or do an inspection. There is literature evidence that both agency and hospital participants do spot-checks.

The reported reasons for doing spot-checks are varied, but the data revealed that one reason on the agency side was that of demonstrating collegiality and interest in the agency nurses. The AHASA participant described the nurses' reactions to the agency manager's weekly hospital visits on night duty as follows:

"...the nurses appreciate this much more when the big boss comes to visit them on night duty...I make it a point, or once a week to go to each client...on night duty... (AHASA, pg. 87).

One participant articulated that the spot-checks are conducted in the hospital as part of the orientation process.

"You do spot-checks... place her with a permanent nurse... the sister must guide and see whatever she must do..." (FG2, P3, pg. 25).

The literature thus confirms that spot-checks are proven to be of value for hospitals, agencies and agency nurses, albeit for different reasons.

Sub-theme 6.4: Evidence of quality nursing care

Evidence refers to proof or signs that quality nursing care is rendered by all nurses. This forms the core of all nursing activities in hospitals and is, therefore, an important control measure to evaluate the effectiveness and efficiency of all nursing activities because evidence, or lack there-of, have important clinical nursing practice and medico-legal implications for all nurses, hospital managers and nursing agencies.

The data revealed many examples as evidence of quality nursing care, which was rendered by agency nurses and seemed to indicate general consensus among participants that agency nurses made a valuable contribution to ensuring the delivery of quality nursing care in district hospitals. The following quotes explain the evidence of quality nursing care in the words of the participants:

> *"…some of them even go extra mile… they will help each other when they're finished, they will share…their task plus other people assists others, work as a team and* [engage in] *good communication with others…" (FG3, P1, pg. 47).*

> *"… she said can I do the half wash? Ek sê (I said): "Huh?" So then she did that. I thought joh. And now she is still doing it from January. She is continuing it, now the other nurses working with her is also doing that now. Back to basics again…She continues with that…" (FG2, P3, pg. 33).*

The AHASA participant seemed to agree that agency nurses were indeed contributing to the delivery of quality nursing care. However, he appealed to nurse managers for sensitivity and to take into account that an agency nurse may not be comfortable to move to another ward:

> *"…the confidence of the nurse will get a knock if she has to work in another department where she's not comfortable and then, you know, on short notice, and then…an incident report* [follows] *the next day…" (AHASA, pg. 86).*

This appeal seems reasonable and relates to an agency nurse's competencies for a specific ward for which they accepted placement, but the nurse's competencies may

not be sufficient to efficiently and effectively deliver quality nursing care in another ward.

Theme 7: Budget monitoring (4.4.7)

It is generally accepted practice that nurse managers are responsible for their facilities' agency nursing budgets, which needs careful monitoring and control measures to ensure that allocated budgets are not overspent.

Sub-theme 7.1: Control of the agency budget

Control of the agency budget refers to the authority that manages a hospital's agency budget. Permanent staff salaries resort under a hospital's personnel budget. The budget for agency nursing appears separately under the "Goods and Services" budget item. Participant 3 explained that her hospital's agency budget was allocated to, and was therefore, controlled by the nursing division and was sub-divided among the general nursing- and speciality nursing wards, with control vested in the Area Managers Nursing (commonly referred to by WCGH nurses as ASD's):

> *"…The ASD's get the money…speciality or general or wherever. We've…got a budget…" (FG2, P3, pg. 28).*

Participant 1 stated that her hospital only had a nursing budget, but did not specify a dedicated agency nursing budget:

> *"It is just the nursing budget…there* [are] *lots of…reasons why we can…overspend… So now we got a leeway of not looking at the budgets per say" (FG2, P1, pg. 29).*

It is the experience of the researcher that some hospitals centralise decision-making regarding medical-, nursing- and other agency staff and it may be the case in this instance.

The hospital represented by Participant 2 appeared to have an allocated agency budget, which was centrally controlled from the office of the HoNS:

> *"…we don't have…*[an] *allocated budget per department. We work on a combined budget for agencies" (FG2, P2, pg. 29).*

Thus, the data revealed that there are differing levels of control over agency budgets in district hospitals and the ability to source agency nurses.

Sub-theme 7.2: Monitoring

Monitoring refers to the actions taken by district hospitals to check and supervise expenses related to agency nursing. It appears that district hospitals have adequate processes in place to monitor agency nursing expenditure.

All participants mentioned that monitoring commenced when they would do their monthly nurse staffing where the staff shortages for the ensuing month would be determined. Where a decision was taken to utilise agency nurses it needed to be pre-authorised:

> *"…we also couldn't recruit agency just as we liked…We also have a list, we have a pre-authorisation book; so that is the system that we brought in…all the open spaces we book it on NIMS…" (FG1, P2, pg. 11-12).*

Participant 2 confirmed that her hospital followed a similar process when she stated that:

> *"…the managers of each of the areas…they need to do the projections based on the factors that we recognise for agency procurement…" (FG3, P2, pg. 47).*

The data also revealed that district hospitals followed additional processes to monitor agency nursing budget expenses, e.g., weekly NIMS reports:

> *"…at the end of the week on a Monday they draw the NIMS report, so NIMS can give you a report of your expenditure…" (FG3, P1, pg., 48).*

Participants also mentioned monthly meetings where the agency nursing expenditure would be discussed, e.g., at Financial Management Committee (FMC), budget meetings and meetings with the hospital CEO, e.g.,

> *"…there is your…systems in place, your FMC, your budgeting meetings and then your CEO here by our hospital…" (FG 1, P2, 13).*

Sub-theme: 7.3 Avoiding overspending

It emerged from the data that hospitals followed similar procedures to avoid overspending their agency nursing budgets as evidenced by a participant who stated: *"We obviously get…a agency budget…divided into…twelve months…we stay within the budget…" (FG1, P1, pg. 12).*

As a practical measure to manage staff shortages, one participant mentioned that their hospital reorganised the permanent staff's off-duties: *"…we rearrange the off duties…" (FG4, P2, pg. 65).*

Although district hospitals followed similar processes, it was evident that not all hospitals selected agency nursing as the first option to supplement permanent staffing of the hospitals. Some district hospitals also considered overtime for their permanent staff either before, or in conjunction with, agency nurses, e.g.:

"…we encourage the staff to do a set amount of overtime hours per month so in order to limit the agency budget…" (FG1, P1, pg. 12).

Participant 2 who stated that, confirmed this

"…sometimes [it] *will be a case of: right, we've actually overspent here…you will now need to use…more overtime…" (FG4, P2, pg. 66).*

The WCGH placed a limit of 30% on the amount of overtime that employees could work*, as confirmed by one participant:*

"…you may not work more than 30% of your salary…" (FG4, P2, pg. 67).

However, it has been the experience of the researcher that overtime costs are more expensive than utilising agency nurses, and it is unclear whether participants were aware of this. The data revealed that district hospitals had measures in place to manage agency nursing over-expenditure.

During the data collection and analysis phases, the researcher uncovered three additional themes of interest worth reporting on. Nursing is regarded as a caring profession. All participants are members of the nursing profession and it may not be a surprise that a caring attitude has been displayed during the data collection for this study. The three themes are presented below.

Theme 8: Caring attitude towards agency nurses (4.4.8)

The data revealed a general display of a caring attitude towards agency nurses.

Sub-theme 8.1: Actions displayed by hospitals

It was one participant's perception that some agency nurses may be financially dependent on an agency job and stated:

> *"...we feel that the nurse doesn't have* [an] income*, a full-time salary and...she needs the work..." (FG2, P2, pg. 26).*

Although the hospital seemingly did not need the services of the agency nurse, one participant expressed difficulty in sending the agency nurse home, because the hospital was located in a less safe area and it was during the night:

> *"...the ward is full staffed and all those things...I find it difficult to send the staff member home in the area that we are and its night..." (FG3, P3, pg. 44).*

Another participant expressed their hospital staff's willingness to assist agency nurses with upskilling when stating

> *"...our staff don't mind teaching and helping and sharing..." (FG4, P2, pg. 62).*

Although this demonstration of care and concern came at a cost to the hospital, it was assumed that the participant made an informed decision to act in the best interest of the agency nurse. It is thus apparent that participants, as members of a caring profession, were able to display care and concern towards agency nurses as colleagues who share the same profession.

Sub-theme 8.2: Actions displayed by agencies

It emerged from the data that agencies, as the employers of agency nurses, displayed care and concern when their nurses encountered difficulties during their placement at district hospitals.

One participant revealed an agency's act of kindness towards an agency nurse who was incorrectly booked to work at the hospital. It appeared that the agency was informed and sent a driver to take the nurse home:

> *"...It was a winter's day, if it was not the hospital's fault the agency would actually send a driver to take the staff member home..." (FG3, P3, pg. 44).*

The AHASA participant also shared an attitude of caring and fairness from an employer towards an agency nurse when he stated that:

> *"...the nurse also admits to being guilty, so what do you do now? You do not crucify that nurse. What you need to do is you need to take her by the hand and need to walk the road with her, guiding her, assisting her...You help her up, you, with your clinical facilitator, you walk with this nurse, you make her feel important..." (AHASA, pg. 94).*

The emergence of such a caring attitude from agencies and nurse managers towards agency nurses who experienced challenges was befitting of members of a caring profession.

Theme 9: Reported disconcerting agency practices (4.4.9)

This theme and sub-theme refers to the views of nurse managers on the reported disturbing practices and conduct of some agencies and agency nurses.

Sub-theme 9.1: Reported agencies' conduct

Participants shared their views regarding some agencies' reported conduct. It emerged that one participant had identified some agency consultants who, being aware of the hospital's preferred requests for agency nurses, would assign these nurses to the hospital and then habitually later call the hospital to offer alternative nurses for placement. In the words of the participant:

> *"...I want her... within a space of an hour after you've sending off that email, you've get a phone call saying: Hi...I just need to do a replacement..." (FG4, P2, pg. 63).*

One participant expressed dissatisfaction with an agency consultant who reportedly forgot to inform an agency nurse that she had to report for duty at the hospital.

> *"...this morning I had somebody who was supposed to come on duty...She didn't come because she didn't get a message from the agency...when I phoned the agency she says: "Oh sorry I forget to send her..." (FG2, P3, pg. 24).*

Another participant shared her awareness of a practice whereby a nursing agency reportedly denied a specific agency nurse shifts at a hospital and instead scheduled another agency nurse to those shifts. The participant stated:

> *"…do you know that she…takes the shifts away from me and then she gives it to whoever…" (FG4, P2, pg. 64).*

A Code of Conduct as well as a contractual arrangement with the WCGH, which, amongst others, also addresses issues of conduct during the course of doing business with WCGH, guide AHASA-affiliated agencies. Agencies are affiliated to AHASA on a voluntary basis and, therefore, it is accepted that not all agencies are affiliated. It is thus unknown whether the reported disconcerting agency practices were committed by AHASA-affiliated nursing agencies and no such insinuation is intended in this report.

Sub-theme 9.2: Reported agency nurses' conduct

The participants shared their experiences about the conduct of some agency nurses that they had observed. One participant related an incident where an agency nurse on night duty reportedly carried out her tasks with her mobile phone in her hand for the entire shift:

> *"…we've had…the one who walk down the whole night with a cell phone in her hand…" (FG4, P2, pg. 5).*

Another participant said she witnessed how agency nurses worked at least two consecutive 12-hour shifts in one hospital. Furthermore, she also revealed that some agency nurses engaged in dishonest practices when they reported for duty, signed the attendance register and then went home after signing in.

> *"…she (agency nurse) worked in the one area for an agency and then in a next shift would be in another area inside the hospital for another agency …and I ask her why are you still here, so they do these things…at a larger hospital where I worked they would also come on duty and go home again and then the shift is already claimed…" (FG3, P3, pg. 51).*

In another example of alleged dishonesty, a participant reported that an agency nurse came on duty and signed in for two dates when she had, in fact, worked for one shift only. In the words of the participant:

> *"…we had cases where a person from the agency would for instance write, write their name in the book maybe for two dates whereas the person only came once. So in order to control that …all the agency staff members need to sign at the central place, which is the night manager's office…"(FG3,P2, pg. 50].*

Theme 10: Agency nurses from other province (4.4.10)

Participants expressed a view that many nurses come from at least two other provinces to do nursing agency work in the Western Cape Province. The data revealed that some agency nurses from other provinces may have questionable standards and competencies.

> *"…we find that a lot of people will sign up with the agencies. They have trained in (Province X)…out of province…and they have a different standard to nursing practice to what we have…" (FG4, P2, pg. 62).*

> "...there is an influx of nurses...particularly...Province X...You...would interview about twenty nurses a week from Province X..." (AHASA, pg. 98).
> *"You get these nurses from Province X who are not competent" (AHASA, pg. 101).*

> *"…they will come from Province Y on leave to Cape Town and they will come and work that month…in Cape Town" (FG1, pg. 7).*

Theme 11: Participants' recommendations

Participants freely expressed their views on practical ways that could be considered to improve the utilisation of agency nurses and to foster better working relationships in the workplace.

Sub-theme 11.1: Recommended actions for hospitals

Hospitals could consider a number of practical ways to improve the general working environment as well as interaction with agency nurses. One participant suggested the re-introduction of five-eighths posts for nurses to allow for greater flexibility. This was supported by F1, P2 as well as FG1 P3 who also supported flexi-time shifts for nurses.

> *"…five eight shifts,…In some of the companies they allow you to work certain days like that…" (FG1, P3, pg. 18).*

It was also suggested that hospitals include agency nurses in their in-service training programmes to ensure that they are upskilled and knowledgeable regarding the hospital procedures as stated:

> *"…in-service training so our nurses in our hospital they are included in that…" (FG1, P3, pg. 19).*

One participant indicated that her hospital extends their bedside teaching functions to nurses and carers who escort patients to hospital. While in hospital they teach the nurses and carers additional basic nursing skills so that, upon discharge, they can take better care of their patients at home:

> *"…my carer must go and sit next to my bed…So then we show her something that we do to make it better for her" (FG2, P3, pg. 41)*

> *"…There was also a request that relief nursing staff be provided for hospitals so that there are no challenges to staff critical clinical areas at short notice: "…then you knew that you must have 5 PN's on your relief team…" (FG3, P3, pg. 57).*

The DNS participant emphasised the importance of adhering to contractual arrangements regarding agency nurses:

> *"First and foremost, your regulatory process must always be in place. So nobody's working out of their frames* [scope of practice]*." (DNS, pg. 82).*

There were other divergent views regarding practical arrangements, e.g. one participant suggested that agency nurses and other be provided with separate tea rooms: *"That's why I say, a space where they can relax…" (FG2, P3, pg. 37).*

Another participant suggested that the generally unfavourable treatment agency nurses receive should be changed, especially the attitudes of other healthcare professionals:

> *"…to protect our profession from the medical side. Because we need to protect our nurses, our integrity and theirs…" (FG2, P2, pg. 39).*

Sub-theme 11.2: Recommended actions for agencies

Participants expressed their views regarding suggestions that agencies could consider, e.g.

> *"…to…improve the quality staff you get from the agency, I would think they should go back to their recruiting process…" (FG1, P1, pg. 19).*

Several participants highlighted the need for agency nurses to work orientations shifts at hospitals before they are placed. This was also supported by the AHASA participant:

> *"…we were not allowed to work if we didn't clock* [an] *orientation shift and I think we [are] not emphasising…it* [enough]*…" (FG3, P3, pg. 53).*

One participant requested that nursing agencies do the same frequency of follow-up visits to their nurses in public hospitals as they do for the private sector. This participant was supported by another when she stated:

> *"…we don't see them,…they did it by the private hospitals or tertiary hospitals, maybe if they do* [it in the public sector too]*, so there's no follow up on the people and there are people that's employed for that." (FG3, P3, pg. 55).*

It was also suggested that nursing agencies revisit their verification checks regarding agency nurses' competencies. In the words of one participant:

> *"…maybe the agencies could improve by…testing their clients and…they need to have a certain percentage…" (FG4, P3, pg. 71).*

One participant made an appeal for nursing agencies to operate for extended hours so that they are contactable in cases of emergency when agency nurses to=do not report for duty, or when a hospital is in urgent need for staff. The participant said:

> *"Some of the agencies work right through the night, dealing with institutions that worked 24 hours, but* [not all of them] work *that 24 hours. But even if they could just…work till ten o' clock* [at night] *at least and then the hospital will be settled, because if somebody doesn't rock up at seven o clock* [in the morning], *we can still contact some of them…" (FG4, P3, pg. 74)*

Sub-theme 11.3: Other recommendations

Participants made strong recommendations regarding improved dialogue between the DNS and hospitals regarding contractual arrangements, exploring the establishment of a nursing bank and consultation with hospital staff and using the provincial Nurse Managers' Forum meeting as a platform for regular discussion on agency nurses and-nursing.

> *"However we need to work towards…the new system that…the Department would like to embark on,* [which] *is a nursing bank…" (DNS, pg. 75).*

AHASA advocated for better cooperation between permanent- and agency nursing staff and made a practical suggestion about educational activities to strengthen nursing and cooperation between public- and agency sector nursing staff. The AHASA participant also alluded to the establishment of a vetting centre for nurses in the province, which could strengthen screening procedures to the benefit of all employers of nurses.

> *"…there's this subtle war between an agency* [nurse] *and a permanent nurse… We need to break down the walls…if you want better communication, cooperation between nurses…" (AHASA, pg. 92).*

> *"…annually we have…open days, we have workshops where we invite nurses…Agency nurses…We bring agency nurses, hospital permanent nurses…together in a workshop, or in a seminar…" (AHASA, pg. 96).*

4.5 CHAPTER SUMMARY

A qualitative study was done to explore the views of nurse managers on the utilisation of agency nurses. Data was collected from 14 participants in four focus group interviews, a face-to-face interview, and a telephonic interview, using semi-structured questionnaires.

The Framework Approach was used to analyse the data thematically. The findings were arranged according to the broad themes of the interview questionnaires focusing on common practices in hospitals regarding sourcing, deployment and supervision of agency nurses, agency budget and the provision of quality nursing care. The findings revealed that similar common practices for sourcing, deployment and supervision of agency nurses took place in hospitals. It also revealed that hospitals have structures and mechanisms in place to monitor and manage agency expenditure. There was also evidence that agency nurses provide quality nursing care.

Unanticipated findings from the data include examples of unacceptable conduct of agencies and agency nurses', the display of caring attitudes towards agency nurses, and nurses from other provinces who do agency work in the Western Cape Province.

Chapter 5 follows with a discussion, conclusions and recommendations.

CHAPTER 5
DISCUSSION, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

5.1 INTRODUCTION

In Chapter 4, the study findings are examined, discussed and presented according to the themes and sub-themes that emerged from the data collection and analysis. In this chapter the findings are discussed and presented in line with the study objectives.

The general nursing shortage causes nurse managers to utilise agency nurses to supplement the permanent nursing staff to ensure that adequate, safe, quality care is rendered (Rispel & Moorman, 2015:1). However, this often creates complex dilemmas for nurse managers and it was for this reason that the researcher explored this topic for research, because nurse managers' views may provide valuable insight and suggestions to support efforts to improve the utilisation of agency nurses and ensure quality nursing care (Jooste & Prinsloo, 2013:1; Rispel, Blaauw, Chirwa & De Wet, 2014:1).

Table 5.1: The WCGH vision, values and principles and PNS linkages (WCGH, 2014: xv; WCGH, 2016:14-16).

Vision of the WCGH: Access to person-centred, quality care		**Provincial Nursing Strategy (PNS) focus area:** Nursing Leadership and Governance
The 6 values	**7 underlying principles**	**Objectives**
Care ⟷	Person-centred quality care ⟷	Consistency in the quality nursing practice
Competence	Outcomes-based approach	Provide clarity re. interpretation & application of different scopes of nursing practice
Accountability	Primary Health care philosophy	Support, supervision, mentoring & coaching
Integrity	Strengthening District Health	Clarity roles & responsibilities of NMs, especially Operational Managers
Responsiveness	Promoting equity	
Respect	Operating with efficiency	
	Developing strategic partnerships	

The WCGH vision of access to quality, person-centred care must be delivered based on the six departmental values of displaying a caring attitude, competency in carrying out duties and responsibilities, accountability for professional actions and omissions, integrity, responsiveness to service needs, and respect for people (WCGH, 2014: xv). For nurse managers in district hospitals utilising agency nurses daily, these actions should especially be underpinned by the underlying principles of person-centred care, efficiency regarding performance, the available budget for agency nurses as well as the strengthening of the cooperation between the WCGH, nurse managers, agencies and agency nurses. Nurse Managers in district hospitals would thus have the responsibility to give expression to the vision of the WCGH through coordinating and offering, support, supervision, mentoring and coaching to all nurses in order to ensure that person-centred, quality care is delivered (WCGH, 2014: xv; WCGH, 2016:14-16).

The Provincial Nursing Strategy's Nursing Clinical Governance and Leadership strategic priority (2016) formed the policy framework for this study that was undertaken, firmly based on the Healthcare 2030 document. Thus, this study's focus on quality of care and efficiency, among others, link with the WCGH's Healthcare 2030 departmental vision, values, and principles as well as the Provincial Nursing Strategy's priority given to leadership and governance (WCGH, 2016:14-16; WCGH, 2014:xv-xvi).

Utilisation of agency nurses, in the context of this study, implies the sourcing, deployment, supervision and financial management of agency nurses. Sourcing inevitably links with supply chain and procurement processes, deployment and supervision linked with quality processes and financial management. It is, therefore, interlinked with both supply chain and government financial regulations.

5.2 DISCUSSION

The aim of this study was to explore and describe the views of nurse managers on the utilisation of agency nurses. Thus, the discussion is presented under the study objectives and is supported by relevant literature to either confirm or provide additional perspectives on the findings and conclusion.

5.2.1 Objective 1: Describe common practices pertaining to the utilisation of agency nurses

Objective 1 had three probing statements, i.e., sourcing, deployment, and supervision of agency nurses, to ensure that participants addressed the specific areas of interest. Participants actively contributed to the discussions in the four focus group interviews during which they freely shared their views and experiences around the utilisation of agency nurses.

5.2.1.1. Sourcing of agency nurses

Sourcing refers to the processes that hospitals implement to determine the number and categories of agency nurses they would need to strengthen their permanent staff compliment and the steps to be taken in requesting the nurses from the agencies. Porter's Value Chain model describes sourcing as a primary activity (an inbound logistic) that refers to how the agency nurses are procured before they come on duty. It is also classified as a secondary, or support, activity (procurement as well as human resource management) that has to do with all the systems and processes involved in the procurement of resources for service delivery

5.2.1.1.1 Determining the numbers and categories of agency nurses needed

Participants confirmed that they all used a similar approach, i.e., monthly staff planning, to determine the number and categories of agency nurses needed. According to Di Martinelly, Riane & Guinet (2009:6), applying the value chain model would help to identify activities that create value for care while keeping costs under control. It was observed that nurse managers expressed their views easily on this aspect of agency nurse staff planning as no participants expressed problems or challenges with it. Accountability for agency nursing expenses seemed to determine their acceptance of this practice/activity of determining the numbers and categories of agency nurses.

However, there is another dimension to sourcing on which participants expressed their views. This relates to the process of requesting agency nurses on NIMS according to the nursing skills that hospitals need.

5.2.1.1.2 The sourcing and selection of agency nurses on NIMS

The NIMS is the prescribed system for sourcing agency nurses. Clerks use the NIMS electronic procurement system to communicate the required nursing skills needed to all WCGH-approved nursing agencies. Agencies then respond by placing available agency nurses' names and skills on the system where nurse managers can select the nurses that meet their criteria for placement.

Participants confirmed compliance with using NIMS to request agency nurses, e.g. "*...this system called NIMS...where we...electronically requesting nurses on the system ...*" (FG3, P1, pg. 42).

However, participants expressed frustration with using the NIMS and stated various reasons why the NIMS was perceived to be challenging. The reasons related to the limited, or non-availability, of the required nursing skills, slow responses from nursing agencies, time spent on the sourcing process daily and the conduct of certain agencies. One participant explained: *"...it's time consuming...that is my frustration with the NIMS system...it cause*[s] *a lot of...constraints to get the body into your ward..."* (FG2, P2, pg. 42).

The district hospitals included in this research all utilise agency nurses on a daily basis and, therefore, the frustrations reported are often experienced. While the feelings of frustration among participants were real, no best practices for an improved utilisation of the NIMS could be identified from the data, so the frustrations continue.

Participants' observed body language and facial expressions were congruent with the shared views on this topic, e.g., P1 in FG1 echoed the sense of frustration when her comment was made with a solemn facial expression, very soft tone of voice and eyes cast down. Thus, the frustrations participants continue to experience daily with the use of the NIMS is an area that should receive further attention because the functioning of the system and the processes involved were presented as major challenges occurring on a daily basis.

Although agency nurses are an expense, this is provided for in hospital budgets. According to Montgomery and Oladapo (2014:173-174), talent acquisition, retention, and replacement of staff for healthcare organisations generally form part of a complex variety of costs including labour, consumables, technology, and administrative activities. Labour, in the context of this research, could include agency nurses and

administrative activities as well as collective time spent by nurse managers, NIMS clerks, and other support staff at hospitals that are involved in the sourcing of agency nurses. The authors further state that, given the overall rise in healthcare expenditure, these costs are unsustainable.

The indirect costs associated with sourcing for district hospitals in the Cape Metropole (where the participant hospitals are located) are unknown. One research study by Rispel and Moorman (2015:5), reported on in Chapter 2 (2.5.2.2), calculated the indirect cost associated with the recruitment and management of agency nurses at two large SA public hospitals. The study found that the indirect costs per week exceeded the direct costs.

In order to optimise the sourcing process, current practices could be analised and diagnosed applying Porter's model to identify the best strategy to follow that will create value for care. It is sufficient to state that the current sourcing of agency nurses could be re-evaluated to identify opportunities to create value for care (Di Martinelly, Riane & Guinet, 2009:11).

5.2.1.2 Deployment of agency nurses

Deployment refers to the common practices employed at district hospitals to place agency nurses coming on duty. There is a paucity of research studies, and the researcher could not find meaningful articles related to the deployment of agency nurses.

Participants stated that it is common practice in hospitals to make internal re-arrangements among permanent staff based on patient care needs. By the time an agency nurse arrives at the hospital, they may no longer be required for the ward, which they were booked for.

Participants expressed their views on the deployment of agency nurses and it has become apparent that there is uniformity of practice to utilise the agency nurse elsewhere. "*...you must use that body that is coming and that body is going to be paid...*" *(FG2, P3, pg. 25) and "There's always space for an extra pair of hands..."* (FG4, P2, pg. 62).

However, although it may be common practice, nurse managers need to take certain factors into account when deciding to deploy the "extra" nurse. These factors relate to the nurse's authority to practice, the scope of practice and their competence to function in the new placement area. This fact is supported by Dall'Ora and Griffiths (2017:2) who state that nurses should be competent and skilled enough and deployed to similar clinical areas to the areas where they usually practice.

5.2.1.2.1 Authority to practice

The nursing and midwifery professions in SA are strictly regulated. In terms of sections 31(1) and (3) of the Nursing Act, 2005 (33 of 2005), no nurse may practice the profession and, therefore, no one may employ a nurse who is not registered or enrolled with the South African Nursing Council (SANC) (Nursing Act, 2006:25).

According to section 31(11) of the act, doing so constitutes a criminal offence (Nursing Act, 2006:26). Thus, it is illegal for nursing agencies to employ nurses to perform nursing duties without verifying that such nurses are registered or enrolled with the SANC. The AHASA participant confirmed that checking nurses' current registration or enrolment constitutes AHASA's first step in their verification process.

The SANC maintains an electronic register (commonly referred to as the e-register) that allows any member of the public, including employers, who is in possession of a nurse's SANC practice number, to check such nurse's registration status. However, the SANC provides only an annual printed receipt that a nurse can provide as proof that they are licensed to practice for any given year. NM's currently accept that nursing agencies have verified their nurses' current SANC status and that nurses entering their hospitals are licensed to practice nursing and midwifery.

Although no participants alluded to identity fraud whereby someone would pose as a nurse, the researcher is aware of one instance in the past where such identity fraud had taken place. If such practices were currently taking place, nurse managers would be unaware of such practices in their hospitals. This could have serious medico-legal implications for the individual, nurse managers, and the nursing agencies as the employer of agency nurses. Thus, the only way to verify that an annual practicing

receipt is that of a particular nurse, is to verify the receipt with such nurse's identity document in instances where a nurse's identity is in question.

5.2.1.2.2 Scope of practice

The SANC scopes of practice for the three categories of nurses are approved under the Nursing Act and are contained in the SANC Regulation 2598, describing the acts and procedures a professional nurse, enrolled nurse, and an auxiliary nurse may perform. The scope of practice details what nurses are educated, competent and authorised to do and outlines the context in which nurses function (SANC:2). The former Minister of Health and Welfare passed this regulation on 30 November 1984 under the previous Nursing Act, 50 (Act 50 of 1978), as amended in 15 February 1991. While the SANC is busy updating and aligning all regulations with current legislation and practice frameworks, Regulation 2598 remains in force.

The deployment of an agency nurse would need to be agreed upon by the nurse manager, the agency nurse and the nursing agency. It is imperative that the nurse manager establishes whether the agency nurse has the competencies to function in the area where they will be placed. It emerged from the data that at least one participant (a deputy to the HoNS) did this.

Once the nurse manager is satisfied that the agency nurse has the competency, the latter may be relocated with their permission. This appears to be acceptable to AHASA, provided the relocation is by mutual agreement. Thus, the evidence suggests that it is accepted as fair practice that deployment should be by mutual agreement based on the competency of the agency nurse and ensuring that support is offered by permanent staff.

5.2.1.2.3 Competency to practice

In this section, competency is discussed in the context of being a considered requirement before deciding to relocate an agency nurse away from her originally allocated placement. Elsewhere, it is discussed in the context of reflecting participants' views on the competencies of agency nurses.

The SANC defines competency as the requirements that need to be met in order for a nurse to be considered a skilled practitioner. This means a nurse must demonstrate the ability to integrate and apply the knowledge, skills, judgement, attitudes, values, and abilities required to practice safely and ethically in a designated role and setting. Furthermore, the SANC requires that every nurse should stay abreast with developments in an area of practice in order to maintain their level of competence (SANC, pg. 2). Thus, competency in areas of placement is legislated and must be considered when deciding to re-allocate the nurse.

The evidence confirmed that at least one participant (a deputy to the HoNS) was aware of the important consideration of competencies regarding placement. She would ask the agency nurse: *'Where did you work before? What kind of work did you do in that hospital or in what ward…"* (FG2, P3, 24). However, it is not known whether nurse managers in all district hospitals have a mechanism in place for a rapid assessment of agency nurses' competencies before re-allocating them. No other participants contributed to the discussion on doing an assessment before re-allocation.

In fact, there is supportive evidence that nursing agencies take action to improve competencies only after the discovery of incompetent acts: *"…we send them back to the agencies…" (FG4, P2, pg. 61)* and *"…we will then say to the agency staff…..this person is maybe not suitable…" (FG4, P2, pg. 62-63).*

A 2012 Australian study states that leaders from the academic and clinical contexts should form partnerships to use practice development and knowledge translation as important mechanisms to advance nursing practice. A whole system approach to improving nursing practice is required to align the academic and clinical contexts (Walsh, Kitson, Cross et al., 2012:67, 72, 74). This should be expanded to include the nursing agency industry in efforts to develop practice. The aim would be to develop practices that could, among others, create health facilities that are safe and progressive, evidence-based work places (Walsh, Kitson, Cross et al., 2012:72).
The researcher has thus identified this as an area needing further probing for the benefit of, and with the potential for, developing a system that could support informed decision-making and improved practices.

5.2.1.3 Supervision of agency nurses while on duty

Supervision refers to the oversight provided to monitor agency nurses' productivity, performance, conduct and the manner in which they execute their clinical skills. The supervisory function of the professional nurse as team leader is most clearly described in the SANC Regulation 2598, section 1, which states that "co-ordination shall mean the bringing together of the acts of members of the health team to meet the spectrum of identified health needs of an individual or a group".

The evidence suggests that nurses held the view that the professional nurse (sister), as team leader, was the custodian of this coordinating function, implying that co-ordination included the management function of supervision. One participant stated the following: *"...the department even goes that far to incorporate supervising and mentoring, coaching, and you are responsible for the agency nurse as part of your KRA's* [key result areas] *as an Operational Manager.*" (FG2, P2, pg. 33).

Hospitals are busy places of work. Although participants indicated that supervision took place, the evidence suggests that the supervisory function might not be clearly defined as participants referred to agency nurses' supervision in broad terms, e.g. *"...direct supervision on the shift is difficult..." (FG3, P2, pg. 45)* and *"You do spot-checks....the sister must guide and see whatever she* (the agency nurse) *must do (FG2, P3, pg. 25).*

A small-scale study conducted among 45 Portuguese and UK nurses highlighted the importance of clinical supervision in healthcare facilities. The authors reported that a comprehensive framework of clinical supervision for nurses could help to promote quality standards in clinical care and professional skills development of nurses. The authors further reported that clinical supervision is a link to continuing education and offers emotional stability among nurses De Abreu and Marrow (2012:17, 18).
An interesting finding of the study was that 27 of the 45 participants did not provide supervision to their peers and 24 participants stated that they receive clinical supervision (de Abreu and Marrow, 2012:19, 20).

Based on the evidence from participants in this study, it appears that supervision of agency nurses in clinical practice may not be clearly defined. Furthermore, it is evident that informal methods of supervision are applied in district hospitals.
Thus, the researcher has identified this as an area that may be further explored in order to provide guidance on the supervision of agency nurses.

5.2.2 Objective 2: Describe how nurse managers deal with budgetary restrictions pertaining to agency nurses

Control of agency nursing budgets refers to the authority that manages the budget. Participants all confirmed that their hospital budgets made provision for agency nurses.

The idea of application of the value chain model could assist district hospitals in identifying the value-adding activities when sourcing agency nurses. Di Martinelly, Riane & Guinet (2009:2, 6) applied the same value chain model to identify activities that create value in the supply chain process. By using Porter's model, the focus would be predominantly on the secondary (support) activities on how hospitals' financial, human resource, and technological systems could contribute more effectively to the sourcing of agency nurses and management of agency budgets

5.2.2.1 Control of the agency budget

WCGH hospital staffing budgets are divided into a staff, goods and services, and a contingency budget. The staff budget covers salaries and related costs, e.g., housing and uniform allowances for all permanent staff. The budget for agency nursing resorts under goods and services and are allocated at hospital level at the beginning of the financial year (1 April). The researcher became aware that different practices existed regarding the involvement of nurse managers participating in the decision making process to determine the allocation of the nursing agency budget. Participants did not express any views on the matter.

Hospitals' contingency budgets may be viewed as an" emergency fund" allowing hospital decision makers to apply their contingency funds in any unforeseen events.
The evidence suggested that the overall control of the agency nurses' expenditure (from the goods and services budget) was vested at different levels of control within

the hospitals, e.g., one participant said that her agency budget was centralised with the HoNS who gave the final approval for sourcing. Another participant stated that the agency nursing budget was divided proportionally by the HoNS between the various clinical units and was based on the units' historical consumption: *"The ASD's get the money….speciality or general…" (FG2, P3, pg. 28).* This implies that Area Managers Nursing (ASD's) (the divisional nursing heads of clinical units) managed their budgets in a de-centralised manner. Participants did not express any particular views regarding the control of their agency nursing budgets, but the researcher did not assume that they necessarily endorse these controls.

5.2.2.2 Monitoring of the agency budget

Participants were very explicit about the various ways that have been implemented to monitor the agency nursing expenditure. It was clear that all district hospitals had adequate processes in place to monitor their budgets.

The processes ranged from first considering a re-shuffle of their permanent nursing staff when doing the monthly staff planning (often referred to as the monthly change list), then proceeding to determine the need for agency nurses at least two weeks ahead of time, and, finally, obtaining pre-authorisation for the requests. Additional processes included monitoring weekly reviews of the NIMS report that provided hospital-specific expenditure and scheduled monthly meetings between nursing, finance, and the hospital CEO. These processes served as confirmation that, according to Porter's value chain model, the hospitals' management, financial, and human resource infrastructure were in place to support nursing managers' efforts to effectively and efficiently manage their agency budgets.

Some of the participants revealed that sourcing agency nurses to augment their staffing needs was not always their first choice. Instead, they would consider overtime shifts for their permanent staff first.

The researcher became aware of a costing exercise performed at a WCGH specialist hospital confirming that the short-term utilisation of agency nurses was less expensive than overtime. However, the evidence suggested that participants monitored both agency and overtime expenditure to ensure that they stayed within the allocated budgets.

5.2.2.3 Direct versus the indirect costs

It is evident that the control over, and monitoring of, agency budgets was largely focused on the direct costs. In a national survey conducted in 2014 of public hospitals in all nine SA provinces, it is reported that agency costs had risen from R914.29 million in 2005/6 to R1.49 billion by 2009/10. It is reported that this final total of R6.47 billion is enough to appoint either 5369 professional nurses or 12 441 auxiliary nurses (Rispel & Angelides, 2015:6-7). The findings of the study thus provide valuable insight in the enormous costs involved with agency nursing.

Rispel and Moorman's (2015:1) study on the indirect costs of agency nurses in two public hospitals is discussed in Chapter 2, 2.5.2.2, but it is briefly mentioned here to draw attention to the hidden costs of hours spent on the recruitment, orientation, and supervision associated with agency nurses. The researcher is not aware of similar studies that may have been performed at district hospitals in the Cape Metropole. Indirect cost elements that were quantified included the process and resources involved in identifying the need for agency nurses, recruitment and orientation, supervision, managing problems, and the verification and processing of invoices. The study found that the indirect costs exceeded the direct costs (Rispel and Moorman, 2015:5).

Thus, while the direct costs of utilising agency nurses appear to be less, Rispel and Moorman's study clearly reveals important insights about the total cost of agency nurses and nursing bringing a new dimension to the way in which healthcare organisations view cost efficiency.

5.2.3 Objective 3: Describe how nurse managers deal with the provision of quality nursing care when utilising agency nurses

The SA health sector's obligation to ensure quality healthcare services is rooted in the legislative framework and mechanisms directed by the National Health Act, 2003 (61 of 2003) and the national Office of Health Standards Compliance, under which it is a statutory obligation to comply with the National Core Standards (NCS) for healthcare facilities (WCGH, 2014: xiv). The NCS document states that the national Department of Health *"...is committed to providing the best quality care to patients and users of health services..."* and it was for this reason that standards were set to give guidance to rendering a quality health service *(NDoH, 2011:2)*.

The NCS are divided into seven domains, i.e., (i) patient rights, (ii) patient safety, clinical governance and care, (iii) clinical support services, (iv) public health, (v) leadership and corporate governance, (vi) operational management and (vii) facilities and infrastructure. The NCS document aligns the first three domains as priorities to illustrate the importance the NDoH attaches to the delivery of quality health care to its patients (NDoH, 2011:3).

Linked to the quality directives of the national department, the 2030 vision for the WCGH is having access to patient-centred quality care (WCGH, 2014:x). Focus on quality improvement in patient-centred care was given particular importance when the WCGH formulated a specific vision for quality of care. This vision has three dimensions, i.e., (i) an individual dimension from a patient perspective, (ii) a health system dimension that encompasses coverage, access, standards, efficiency and effectiveness, and (iii) a population dimension (WCGH, 2014: xiv).
In the context of this study, quality refers to the activities of verification of qualifications and NMs' views on competency and the orientation of agency nurses. Thus, the focus is on the health system dimension. Sub-themes that emerge from the data focus on the orientation of new agency nurses, competency assessment, and NMs views on agency nurses' delivery of quality of care.

5.2.3.1 Orientation of new agency nurses

The orientation of any nurse who is new to a health care facility is an important factor in familiarising the novice to the physical environment, layout of the facility and ward, team members, the routines, important policies, etc., that would give them a sense of security and of becoming familiar with the new working environment. This view is supported by the United States of America's Institute of Medicine's suggestion of effective communication, education and adequate orientation procedures for agency nurses (Adams, Kaplow, Dominy et al., 2015:1).In reference to the orientation role of nursing agencies in the orientation of agency nurses, the AHASA representative phrased it that orientation *"...gives the candidate the opportunity to check out the hospital. And then together they decide whether they are good for one another" (AHASA, pg. 93).*

There is a paucity in the literature regarding specifically investigating the orientation of agency nurses. The researcher identified three articles related to the orientation of new graduate, novice nurses although they focus on the employment and orientation of permanent staff. The literature describes orientation in various ways, mainly by way of its content, e.g., an orientation model with a high-level focus (Horwarth, 2010:10), a programme combining didactic content with hands-on clinical experience, and a structured internship programme (Glynn & Silva, 2013:173). Nonetheless, it appears that the content of orientation programmes is customised to fit the needs of both the novice nurse and the healthcare facility.

The high-level focused orientation programme is composed of input from a nursing school that trains the new nurses, the State Nursing Institute, and hospital representatives. These role-players had contributed to the orientation programme content based on what they had perceived to be important topics. These included the top five diagnostic-related group of diseases, the top three nurse-related incident reports, and the key skills sets needed by novice nurses (Horwarth, 2010:10).
The structured internship orientation programme content is based on the contributions of new graduate nurses' shared experiences and expectations of the programme and are identified as (i) acquiring new knowledge and skills, (ii) becoming more competent, and (iii) assistance with role transition. The study found that the programme was very helpful and mentions that the roles of a preceptor and Clinical Nurse Specialist in specialist departments are key to the success of the programme (Glynn & Silva, 2013:173).

Based on the evidence in this study, participants referred to orientation broadly. It appeared that hospitals' orientation programme content varied in terms of content and duration. Participants, who indicated that they do orientation, expressed their views on the opportunities and their willingness to embrace agency nurses and assist agencies to orientate agency nurses for the mutual benefit of both the hospital and the agency nurse. Other participants confirmed this. However, it also became evident that there were challenges with the orientation of agency nurses.

> In the words of the participant: *"…there's also…*[an] *orientation programme in the ward, but if a person comes to work there* [is] *no time to work through an orientation programme…" (FG3, P2, pg. 45).*

Given the busy nature of hospital work, this statement was understandable. It is an area, which could be further explored. The DNS representative confirmed that it was a contractual requirement for nursing agencies to orientate their nurses before placement at WCGH facilities:

> *"...we request that all nurses…entering the service must have undergone orientation. It is not stipulated in the contract" (DNS, pg. 79).*

After re-checking the audio tapes, the researcher called the participant to clarify this statement and the participant confirmed that it was indeed a contractual requirement. The AHASA participant confirmed this when he stated that their agency nurses were placed at facilities for orientation:

> *"…you will shadow a senior for say, two days, maximum four days…" AHASA, pg. 93).*

Nursing agencies are affiliated to AHASA voluntarily and it is not clear whether all are indeed implementing this rule. Only one participant mentioned that there was one agency who said that their nurses should work at a facility for at least one day before placement. Other participants did not confirm this. Given the fact that not all agencies are affiliated to AHASA, the researcher has identified this as an area of interest, which could be further explored to determine which provisions are in place, or need to be provided, for a regulatory framework in monitoring adherence and taking remedial steps or legal action for non-compliance.

Thus, it is clear that district hospitals and nursing agencies engaged in agency nurse orientation. However, the extent to which this complied with the contractual requirement might vary, e.g., nursing agencies employ limited numbers of clinical facilitators (CF's) and it could be very challenging for them to coordinate training and follow up of all the agency nurses who are placed at the eight district hospitals in the Cape Metropole.

Furthermore, the role of the CF in orientation appeared to be obscure as the evidence did not highlight the CF's active participation in hospital orientation programmes. The researcher identified this as an area that should be further explored because a joint, coordinated effort could yield positive results and contribute to improved patient-centred quality care.

5.2.3.2 Competency assessment

Competency refers to a nurse's ability to perform nursing tasks correctly and within their scope of practice. A competency assessment means that the nurse's nursing knowledge and practical skills are evaluated.

Demonstration of proficiency in nursing procedures is necessary to meet the requirements of healthcare organisations, because it is the foundation for quality patient outcomes (Franklin & Melville, 2013:25, 26). It is also a mandatory requirement of the SANC.

In addition, competency also has implications for the professional status and image of nursing as well as the perceptions and impressions that patients and other members of the health team may have about nurses (Ajani & Moez, 2011:2). Furthermore, Franklin and Melville (2013: 26-27) cite Tilley (2008) and Tanner (2006):

> *"Assessing competence in nursing can be challenging as nursing involves complex interpersonal knowledge and clinical judgment measures (i.e., in the form of noticing, interpreting, responding and reflecting) rather than just a series of psychomotor actions assessing clinical expertise."*

It is evident from the literature that competency assessment is critically important to ensure safe, skillful nursing care. The AHASA participant mentioned competency assessment as the critical second step in the nursing agency's verification process of new agency nurses. The participant reported that it consisted of phases: writing a test in which they had to obtain at least 70% – assessing their theoretical knowledge – and then an AHASA CF would assess their clinical skills. While this performance standard is prescribed for AHASA-affiliated agencies, it is not clear how the organisation monitors agencies' compliance. The DNS participant confirmed that not all WCGH-approved nursing agencies were affiliated to AHASA.

In addition, it was unknown if, and how, unaffiliated nursing agencies did competency testing of new agency nurses. Anecdotal evidence suggested that NMs were generally not aware of which agencies were affiliated and which not. Although this might not be of significance to NMs, it might be possible for the DNS to link incidents to agencies,

provided the incidents were captured on the NIMS. Such information might be of value when the WCGH adjudicated tender applications for nursing agencies.

It was evident from the participants' contributions that hospitals' involvement with competency assessment commenced with a rapid review of the agency nurse's profile, which contained a summary of their competencies and which would be reflected on the NIMS. This information allowed NMs to select agency nurses who met the criteria for clinical areas for which placement was requested. However, provisional selection, based solely on what was reflected on the NIMS, may be misleading because, according to one participant, some agency nurses would indicate to the nursing agency that she has experience in a particular field, but when she is placed and is unable to carry out the expected duties, the agency nurse would then reveal that she had her last exposure to that area during her student days.

The researcher has identified this as an area of possible risk. It is unknown what the frequency of such incidents are, because the busy work schedules in hospitals make it impractical for shift leaders and ward managers to interview every agency nurse who reports for duty. However, this reported incident raises awareness of the potential for dishonesty that may go unnoticed if nursing agencies fail to do proper verification checks, including reference checks.

5.2.3.3 NMs' views on the evidence of quality care rendered by agency nurses

Evidence, in the context of this study, refers to proof that quality care was delivered by all nurses, but with a particular focus on agency nurses.

Participants shared their views and provided examples of quality care that was rendered by agency nurses. The evidence provided by the participants, in their own words, indicated many examples serving as evidence that agency nurses provided quality nursing care.

One participant's contribution on how her hospital utilised agency nurses to sort and direct the daily volume of patients to the correct areas, enhanced patient flow and reduced bottlenecks at the Enquiries desk of the hospital.

However, the researcher noted the contrasts between participants' views on the quality of care rendered and the examples they provided about agency nurses' competencies, non-performance, conduct and participants' actions to avoid re-booking agency nurses who were not performing to the expected standards.

A study, conducted in the USA investigating the use of temporary nurses and nurse and patient safety outcomes, found different impacts on falls and medication errors of different kinds of temporary staff. The authors report that patient falls increased only in areas where more than 15% of temporary registered nursing hours was utilised and they concluded that the type of temporary staff used might not be the critical factor related to patient falls. Instead, it may be the total hours of care provided by temporary staff (Bae, Mark, & Fried, 2010:342). Another study was done of 605 UK general and specialist wards about cost and quality issues related to temporary nursing staff. Although the authors declared that their findings could not be generalised to all wards, they concluded that the overall quality scores were no different between wards that hired temporary staff and wards with permanent staff only (Hurst & Smith, 2010:287).

Although the focus of this research is on the views of NMs regarding the utilisation of agency nurses, and not on nurse and patient safety outcomes, the contrasting views expressed by the participants may highlight a potential need for a comprehensive study to be done in district hospitals on cost and quality outcomes related to agency nurse staffing.

5.2.4 Unanticipated findings emanating from the data

Three unanticipated themes emerged from the data, i.e., (i) caring attitudes towards agency nurses, (ii) reported disconcerting agency practices, and (iii) agency nurses from other provinces working in the WCGH.

5.2.4.1 Caring attitudes towards agency nurses

Participants displayed a general attitude of care and concern for agency nurses. This was evidenced by hospitals' staff actions to accommodate them in various ways during the course of their placement at the hospitals.

Nursing is regarded a caring profession and it would generally be expected of its members to display a caring attitude towards own colleagues.

The AHASA participant suggested that open days could provide an avenue for the WCGH and nursing agencies to improve communication.

This suggestion could be considered, because it would provide opportunities to build bridges and improve general communication and mutual understanding between permanent and agency nurses, nursing agencies, and NMs.

5.2.4.2 Reported disconcerting agency practices

Participants expressed their views on incidents of alleged unacceptable conduct displayed by some nursing agencies. The nature of some of the reported acts of unacceptable conduct could be linked to unacceptable nursing agency conduct in the UK that was described in 2.3.7.1. The author of that article highlighted certain attractive benefits some UK nursing agencies offered to lure agency nurses to their businesses.

The evidence in this study suggested that unacceptable conduct might exist in some nursing agencies. The AHASA participant expressed his view on some nursing agencies who engaged in unethical conduct whereby they omit to do proper reference checks and pay the nurses on a daily basis to ensure that the nurses work through these agencies.

The DNS participant reiterated that complaints regarding agency nurses and nursing agencies needed to be reported via the NIMS. Thus, while the data revealed a reluctance by some participants to report unacceptable and unethical behaviour, the revelation of these practices provide opportunities to identify areas for improvement in reporting such acts.

A reluctance to report incidents could have patient safety, cost, medico-legal, and contract management implications for which penalties may be incurred. Furthermore, the findings from this study raised awareness of certain unacceptable conduct and it may warrant further probing because it poses a potential medico-legal risk for patient safety and quality of care.

5.2.4.3 Agency nurses from other provinces working in the WCGH

The data revealed that the WCGH facilities experienced a seasonal influx of agency nurses who came to work in the Cape Metropole, predominantly during December holiday periods. Participants disclosed that the influx was from two specific provinces and the AHASA participant confirmed this. One participant commented:

While it is recognised that SA citizens have freedom of movement anywhere in the country, the data revealed that the participants' concern centred around the competency of these agency nurses. According to the AHASA participant, they interview approximately 20 nurses per week from one particular province and he expressed concern about the quality of these nurses' training: *"...things we take for granted, or that we think our (WCGH) nurses know, they don't know...it is a point of concern to me..." (AHASA, pg. 98).*

However, the views expressed about the competency of agency nurses from other provinces are not dissimilar to the views participants expressed about the competency of agency nurses from the Western Cape Province and it may warrant further investigation to determine the magnitude and severity of this phenomenon.

5.3 LIMITATIONS OF THE STUDY

- This was a small scale study that as performed in the WCGH in urban district hospitals and may, therefore, not be regarded as representative of all district hospitals of the WCGH.
- Although NMs formed the key focus, the voice of nursing agencies and agency nurses were only indirectly represented by one AHASA member in this study.
- The study focused largely on the phenomenon of agency nursing, namely, moonlighting and bank nursing, overtime work was granted minimum consideration.
- The results of this study may be generalisable to other district hospitals only to some extent.
- The results of this qualitative study cannot be quantified and, therefore, it warrants further research on the subject.

5.4 CONCLUSIONS

The findings of this study are in line with the key objectives set out in Chapter 1 and which were discussed in Chapter 5.

The phenomenon of agency nursing was explored in considerable detail and it uncovered certain similarities and differences between countries. The study findings agree that there is a global shortage of nurses. It also reveals that NMs in many countries around the world utilise agency nurses as an accepted human resource

strategy and they experience similar advantages with the utilisation of agency nurses, albeit in varying degrees. The challenges reported by participants indicated the need for a monitoring system for the agency nursing industry.

Therefore, the research question: "What are nurse managers' views on the utilisation of agency nurses?" has been answered.

5.5 RECOMMENDATIONS

5.5.1 Recommendation 1: The agency nursing procurement system

Routine practices conducted at district hospitals have highlighted certain challenges with the sourcing of agency nurses. The implementation of parallel procedures to source agency nurses may have implications for the contractual agreements between the WCGH and nursing agencies.

It is recommended that dialogue between the WCGH, DNS, and NMs be formalised to facilitate communication, problem solving, and information sharing with specific reference to contract management.

5.5.2 Recommendation 2: Direct vs. indirect costs of utilising agency nurses

The short-term direct costs of utilising agency nurses appear to be less, however, a study conducted by Rispel and Moorman clearly reveals important insights about total the costs of agency nurses and nursing when they found that the indirect costs far exceeded the direct costs. This brings a new dimension to the way in which healthcare organisations view cost efficiency.

It is recommended that the WCGH consider doing a similar costing exercise that could inform future decision-making regarding agency nurse utilisation in the WCGH.

5.5.3 Recommendation 3: Verification checks

Given the fact that nurses constitute the single largest group of healthcare professionals, the study findings highlight this as an area of interest that could be further explored.

It is recommended that the WCGH, in consultation with the nursing agency industry, consider the idea of establishing a central verification centre for the province.

5.5.4 Recommendation 4: Joint open days and regional educational event

This study highlights the contribution of agency nurses to the workforce within the WCGH district hospitals. Joint open days could improve the cooperative working relationships that already exist between WCGH staff and the nursing agency industry. It is recommended that the WCGH consider collaborating with the nursing agency industry to co-host joint open days to further improve communication and relationships between all WCGH contract partners.

5.5.5 Future research

The following areas for future research are proposed:

- Exploring the views of agency nurses themselves
- Research the direct and indirect costs at a district hospital
- Explore the idea of a central provincial verification centre.

5.5 DISSEMINATION

The researcher has a written agreement with the WCGH to provide formal feedback once the research has been approved. Arrangements will be made to honour this agreement. The researcher also made a commitment to the participants to provide feedback after the research have been approved. Arrangements will be made to meet with all participants to provide the feedback. Furthermore, it is also required, as part of this study, that the researcher will publish an article once this research has been approved.

5.6 CHAPTER SUMMARY

Participants from the district hospitals in the Cape Metropole shared their views on the utilisation of agency nurses. Their views are considered important because it may provide valuable insight and suggestions that could be considered to support managers' efforts to improve the utilisation of agency nurses and ensure quality nursing care and the efficient use of financial resources.

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APPENDICES

Appendix 1: Ethical approval from Stellenbosch University

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

Health Research Ethics Committee (HREC)

Approval Notice

New Application

23/10/2018

Project ID : 8111

HREC Reference #: S18/08/174

Title: Nurse managers' views on the utilisation of agency nurses in district hospitals

Dear Mr Selvador Bruiners,

The **Response to Modifications** received on 13/10/2018 13:02 was reviewed by members of **Health Research Ethics Committee 2 (HREC2)** via **expedited** review procedures on 23/10/2018 and was approved.

Please note the following information about your approved research protocol:

Protocol Approval Period: **This project has approval for 12 months from the date of this letter.**

Please remember to use your **Project ID [8111]** on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review

Please note you can submit your progress report through the online ethics application process, available at: Links Application Form Direct Link and the application should be submitted to the HREC before the year has expired. Please see *Forms and Instructions* on our HREC website (www.sun.ac.za/healthresearchethics) for guidance on how to submit a progress report.

The HREC will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility, permission must still be obtained from the relevant authorities (Western Cape Departement of Health and/or City Health) to conduct the research as stated in the protocol. Please consult the Western Cape Government website for access to the online Health Research Approval Process, see: https://www.westerncape.gov.za/general-publication/health-research-approval-process. Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.

For standard HREC forms and instructions, please visit: Forms and Instructions on our HREC website https://applyethics.sun.ac.za/ProjectView/Index/8111

If you have any questions or need further assistance, please contact the HREC office at 021 938 9677.

Yours sincerely,

Francis Masiye ,

HREC Coordinator,

Health Research Ethics Committee 2 (HREC2).

Appendix 2: Permission obtained from Department of Health

Western Cape Government
Health

Health impact assessment
Health research sub-directorate
Health.Research@westerncape.gov.za
tel: +27 21 483 0866: fax: +27 21 483 9895
5th Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC_201810_030
ENQUIRIES: Dr Sabela Petros

Stellenbosch University

Faculty of Medicine and Health Sciences

Francie Van Zijl Drive

Tygerberg Hospital

Cape Town

7505

For attention: Mr Selvador Bruiners

Re: **Exploring Nurse Managers' Views on the Utilisation of Agency Nurses in District Hospitals in the Cape Metropole**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following person to assist you with any further enquiries in accessing the following sites:

Khayelitsha District Hospital	**Dr Moses Witbooi**	**021 360 4386**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. By being granted access to provincial health facilities, you are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of your project. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

4. The reference number above should be quoted in all future correspondence.

Yours sincerely

MS A VAN DEN BERG

ACTING DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 2016/11/23

Western Cape Government
Health

Health impact assessment
Health research sub-directorate
Health.Research@westerncape.gov.za
tel: +27 21 483 0866: fax: +27 21 483 9895
5th Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC_201810_030
ENQUIRIES: Dr Sabela Petros

Stellenbosch University

Faculty of Medicine and Health Sciences

Francie Van Zijl Drive

Tygerberg Hospital

Cape Town

7505

For attention: Mr Selvador Bruiners

Re: **Exploring Nurse Managers' Views on the Utilisation of Agency Nurses in District Hospitals in the Cape Metropole**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following person to assist you with any further enquiries in accessing the following sites:

Eerste River Hospital	**Dr Adele Anthony**	**021 902 8019**
False Bay Hospital	**Dr Wendy Waddington**	**021 782 1121**
Victoria Hospital	**Dr Graeme Dunbar**	**021 799 1211**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. By being granted access to provincial health facilities, you are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within

six months of completion of your project. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

4. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR M MOODLEY

DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 14-03-2019

Western Cape Government
Health

Health impact assessment
Health research sub-directorate
Health.Research@westerncape.gov.za
tel: +27 21 483 0866: fax: +27 21 483 9895
5th Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC_201810_030
ENQUIRIES: Dr Sabela Petros

Stellenbosch University

Faculty of Medicine and Health Sciences

Francie Van Zijl Drive

Tygerberg Hospital

Cape Town

7505

For attention: Mr Selvador Bruiners

Re: **Exploring Nurse Managers' Views on the Utilisation of Agency Nurses in District Hospitals in the Cape Metropole**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following person to assist you with any further enquiries in accessing the following sites:

Karl Bremer Hospital	**Dr Linda Naude**	**021 918 1222**
Mitchells Plain Hospital	**Aletta Brown**	**021 377 4781**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. By being granted access to provincial health facilities, you are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within

six months of completion of your project. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

4. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR M MOODLEY

DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 14-03-2014

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Health

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Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following person to assist you with any further enquiries in accessing the following sites:

Wesfleur Hospital	**Dr Ziefred McConey**	**021 571 8052**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. By being granted access to provincial health facilities, you are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of your project. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

4. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR M MOODLEY

DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 25-03-2019

Western Cape Government
Health

Helderberg Hospital
Enquiries: Mr K D Meyer
021 850 4796/076 8307 840

Helderberg Hospital

Lourensford Road

Somerset West

7129

From: The Nursing Department - Helderberg Hospital

For Attention: Mr Selvador Bruiners

Re: Exploring Nurse Managers Views on the Utilisation of Agency Nurses in District Hospitals in the Cape Metropole.

We are pleased to inform you that approval has been granted to do your research at our facility, Helderberg Hospital.

You are welcome to make contact with the following persons to make arrangements should you require access to the facility.

Ms K Ruiters – 021 850 4780

Mr K D Meyer – 021 850 4796/076 8307 840

Hoping that the above will be in order.

Yours sincerely.

Ms K Ruiters

Deputy Manager Nursing

Date: 05 June 2019

Lourensford Road, Somerset West, 7130
tel: +27 21 850 4780 fax: +27 21 852 9841
Private Bag X2, SOMERSET west, 7129
www.capegateway.gov.za

Appendix 3: Participant Information Leaflet and Declaration of Consent by Participant and Investigator

PARTICIPANT INFORMATION LEAFLET

TITLE OF THE RESEARCH PROJECT:
Exploring nurse managers' views on the utilisation of agency nurses in district hospitals in the Cape Metropole.

REFERENCE NUMBER:
WC_201810_030

PRINCIPAL INVESTIGATOR:
Selvador Bruiners

ADDRESS: *(academic department, not home address)*
Fisan Building, Francie van Zijl Drive, Tygerberg, 7505.

CONTACT NUMBER:
021-938 9036

Dear Colleague,

My name is Selvador Bruiners and I am a Masters in Nursing student at Stellenbosch University. I would like to invite you to participate in a research project that aims to explore nurse managers' views on the utilisation of agency nurses in district hospitals in the Cape Metropole.

Please take some time to read the information presented here, which will explain the details of this project and contact me if you require further explanation or clarification of any aspect of the study. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.
This study has been approved by the **Health Research Ethics Committee (HREC) at Stellenbosch University** and will be conducted according to accepted and applicable national and International ethical guidelines and principles, including those of the international Declaration of Helsinki October 2008.

Details of the study
Introduction
Nursing worldwide is regarded as a scarce health human resource and health service organisations have experienced nursing shortages globally in recent years. It has become common practice to utilise agency nurses to amplify the daily shortages with agency nurses. As a current nurse manager the researcher has experienced challenges with the utilisation of agency nurses, e.g. a perceived lack of required competencies, litigations due to medico-legal hazards, increases in patient complaints, poor attitude, lack of commitment and tired, burnt out employees due to working unregulated working hours through agencies.

Significance of the problem
Although the use of agency nurses help alleviate the nursing staff shortages nurse managers experience the challenges mentioned above. It is for this reason that your views as a nursing-

, deputy- or ward manager are significant, because it may provide valuable insight and direction, which nursing managers, nursing agencies and agency nurses can use to address the issues of quality patient care, ethics and nursing standards.

Research question

What are nurse managers' views on the utilisation of agency nurses to augment nurse staffing at district hospitals?

Research aim and objectives

The aim is to explore nurse managers' views on the utilisation of agency nurses in district hospitals. The objectives are to describe (i) common practices pertaining to the utilisation of agency nurses, (ii) how nurse managers deal with budgetary restrictions pertaining to agency nurses and (iii) to describe how nurse managers deal with the provision of quality nursing care when utilising agency nurses.

Research methodology

Four focus groups and two individual interviews will be guided by a semi-structured discussion guide, which is formulated around the research objectives. The data will be audio taped, transcribed and thematic content analysis will be done and interpreted. Data analysis will be guided by the research objectives and using Atlas.ti to identify common themes.

Privacy and confidentiality of information

If you agree to participate in a focus group discussion you will be given a pseudonym with which you will be identified. In this way your identity will be protected when the research findings are reported. The data collected will be treated as confidential and will be protected. Access to the data will be restricted to the researcher, supervisor and field worker. All field notes will be handed in and stored at the Stellenbosch University for at least five years.

Significance of the study

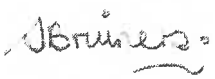
The findings of the study may benefit nursing managers, agencies and agency nurses, because it could provide valuable insight and recommendations to support managers' efforts in improving the utilisation of agency nurses and quality nursing care in hospitals.

Conclusion

Current hiring practices bring with it perceived and unintended consequences with the utilisation of agency nurses. An in-depth understanding of your views as nurse-, ward managers and deputies may support nursing managers' efforts to address current challenges in district hospitals in the Cape Metropole.

If you are willing to participate in this study please sign the attached Declaration of Consent. I will contact you telephonically to inquire about your willingness to participate. If you agree I will request that you bring the completed declaration along to the focus group discussion.

Yours sincerely



Selvador Bruiners
Principal Investigator

Declaration by participant

By signing below, I ..... agree to take part in a research study entitled "Exploring nurse managers' views on the utilisation of agency nurses in district hospitals in the Cape Metropole."

I declare that:

- I have read the attached information leaflet and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... on (*date*) ..... 2018.

.....

Signature of participant

Appendix 4: Semi-structured interview schedule

Questions for the four (4) focus groups

Question 1

What are the common practices that you use to effectively and efficiently?

- Source/request agency nurses?
- Deploy/place the agency nurses that you have requested?
- Supervise agency nurses while on duty?

Question 2

Describe how you deal with the restrictions you have on your agency budgets.

- Prompt 1: How do you monitor your expenses?
- Prompt 2: What actions to you take in managing your budgets?

Question 3

How do you deal with providing quality nursing care when you utilise agency nurses?

- Prompt 1: What would indicate that they have delivered quality care?
- Prompt 2: How do you deal with it when they don't deliver quality care?

Question 4

What suggestions may you have to better manage the need for, and utilisation of, agency nurses in your services?

- Discussions with, and collaboration between, hospitals and agencies regarding orientation of new agency nurses?
- Regular discussions (or a feedback system) with agency nurses placed at your hospital?
- Feedback for consideration to the WCG: Health when planning to approve agencies?

Question 5

You have shared your views on agency nurse utilisation. Do you have any other comments?

Semi-structured interview schedule

Individual interview questions for AHASA

Question 1

What are the common practices that your agencies reportedly use to effectively and efficiently?

- Find agency nurses?
- Deploy/place the agency nurses that have been requested?
- Supervise, or support, agency nurses while on duty?

Question 2

Describe how your agencies deal with the restrictions on hospitals' agency budgets.

- Prompt 1: How do these budgetary constraints impact your agencies' abilities to supply the required demand?
- Prompt 2: What role do agencies play/can play, if any, in assisting hospitals to manage their agency budgets effectively and efficiently?

Question 3

How do agencies ensure that their nurses have the competencies to deliver quality nursing care to your client hospitals?

- Prompt 1: Do agencies check current SANC registration?
- Prompt 2: Do they perform competency testing before placement?
- Prompt 3: Do agencies orientate their nurses to client hospital?
- Prompt 2: How do you deal with complaints received about quality of care?

Question 4

What suggestions may you have to better manage the need for, and utilisation of, agency nurses between the WCG: Health and nursing agencies?

- Discussions with, and collaboration between, hospitals and agencies regarding orientation of new agency nurses?

- Regular discussions (or a feedback system) with agency nurses placed at your hospital?
- Feedback for consideration to the WCG: Health when planning to approve agencies?

Question 5

You have shared your views on agency nurse utilisation. Do you have any other comments?

Semi-structured interview schedule

Individual interview questions for DNS

Question 1

What is the role of the DNS as custodian of the relationship between the WCG: Health and the contracted nursing agencies?

Question 2

What are the common best practices, if any, that hospitals could consider to effectively and efficiently:

- Find/source agency nurses?
- Deploy/place the agency nurses?
- Are there any contractual stipulations and/or agencies' duties to supervise and/or offer support to their nurses?

Question 3

Describe the DNS's role and involvement, if any, in hospitals' agency budgets allocations.

Question 4

Tell us of any contractual stipulations which may exist for agencies to ensure that their nurses have the necessary competencies to deliver quality nursing care in our hospitals.

- Prompt 1: Is it stipulated that they do candidate screening e.g. SANC, background- and reference checks and competency evaluations?
- Prompt 2: Are agencies required to orientate their nurses to client hospital?
- Prompt 3: What consideration is given to complaints about agency nurses when the WCH: Health considers agencies for approval to be used in our facilities?

Question 5

What suggestions may you have to better manage the need for, and utilisation of, agency nurses within the WCG: Health, and between the WCG: Health and nursing agencies?

- Discussions with, and collaboration between, hospitals and agencies regarding orientation of new agency nurses?
- Regular discussions (or a feedback system) with agency nurses placed at your hospital?
- Feedback for consideration to the WCG: Health when planning to approve agencies?

Question 6

You have shared your views on agency nurse utilisation. Do you have any other comments?

Appendix 5: Confidentiality Agreement with Data Transcriber

Declaration by participant

By signing below, I ....Teresa Philander..... **agree to take part in a research study entitled** "Exploring nurse managers' views on the utilisation of agency nurses in district hospitals in the Cape Metropole."

I declare that:

- I have read the attached information leaflet and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... Paarl ..... on (*date*) ..07: 08..... 2019.

.....

Signature of participant

Interviewer	***Oh okay. That is when they look at the budgets?***
Participant 1	At the end of the day we look at the budgets and we give the rate down of how much did we use for agencies and all that.
Interviewer	***That makes sense. And so what are the common practices when you have requested those nurses and they come into your facilities, uhm how do you place them?***
Participant 3	That is according to what you require. Say for instance it's a, you ask for a sister say for instance in Psych. Then you look at the years that that person worked in Psychs. So if you ask for a Psych specific, then you asked for somebody who worked previous in a Psych ward to see that you can place that person if you place me there I know how to give out the medication but by ten o' clock I will be out of the ward. But that's, you, the request that you ask for, that is what you need in your ward. If you need somebody by me, then I ask for somebody who can do dressings. So if it's a staff nurse or a sister, then they know I want somebody who can do dressings. So according to what you need, you ask that.
Interviewer	***Alright.***
Participant 2	I would say uhm it's a process and it's time consuming. So I think the, we must be realistic if we talk about getting nurses to cover the wards because the patient needs the person, the body from seven till seven or seven till four. So there the timeframe is very important. So that is my frustration with the NIMS system because it cause a lot of uhm, how can I say, constraints to get the body into your ward. Because there is a lot of uhm, the person is either booked for another hospital or the person prefer to work at Karl Bremer cause its closest if she stays in Delft so she prefer to work at [redacted] So people have preferences as well. The bank of nurses that the agency recruit, they have also becoming now, preference like. So it's not easy for us to get those people, that requirements that sister mentioned. It's not easy to get that person in your facility, although you will require that specific skills. But if a person pitch up at your facility it is somebody totally different and you have to utilize that body.
Participant 3	You must use it now. Because, say for instance you book me, now at the 99.9 percent I cancel. Now they send her and that is not the person that you requested on NIMS. So then you very frustrated because why I'm used to this person who work here. We know the ins and outs of that person. You know where you can feel free to leave her, but now somebody else is pitching up and that is very frustrating. Now if you sit in front of that computer, you check all the years, you check all the what, whatever, and now it's a different person that came up. And then you very frustrated, really. But we need the bodies to work, really.
Participant 1	Yes, and in my situation, after all those uhm, constraints of getting the person who is not suitable for the job, you know, our geographic area being over the mountain it makes it even worse. Because now like on NIMS somebody or else like the agency tell you that okay, so and so is coming. On the last minute that person cancels and you sit with no soul. Because also the agency can't give me a replacement for this person you know. It's frustrating.
Participant 3	It's really. Because why this morning I had somebody who was supposed to come on duty for a seven seven. She didn't come because why she didn't get a message from the agency to say she must be there today and tomorrow. So when I phoned the agency she says: "Oh sorry I forget to send her..." Oh, just send met that person for tomorrow please. So, it is very frustrating. It is like you said, you sit in front of the computer, you do all your checks and now that person didn't pitch up. Now you must go, please work for me from seven till four. Now the Comm Serve have to work now and now I owe her hours at the end of the day.

Interviewer	***What I hear from what you are saying, there is a sense of frustration with the fact that you request on NIMS and you do not always get what you request. So how does that affect the placement of that staff member who now comes because you've asked for a particular skill, which it sounds that you don't frequently get? There is somebody else and that person comes, so you still have to place that person.***
Participant 3	Like sister said now, you must use that body that is coming and that body is going to be paid at the end of the day. So now you must ask: "Where did you work before?", "What kind of work did you do, in that hospital or in that ward where you worked before?" So now you must put her with somebody else just to guide her if she is coming back in the future at least, show her what to do. You cannot send her home then you've got, like sister said, nobody. Then you sit with one less.
Interviewer	***What happens at your hospital? It sounds as if you, if it's somebody, if it is a replacement that you will actually have a quick discussion in terms of the skills and the competencies? Is that correct? In order to place the person?***
Participant 2	I don't think the screening depends on the manager itself because the first step of screening should be on the NIMS system, the selection of this individual. This person that is allocated or selected for the institution. So the screening is actually not our job, but it became our job, to screen nurses. If they are suitable for the job that they are requested for, and that is the frustration. One the biggest frustrations, that we have to screen nurses or interview them or whatever, and it takes up a lot of time. So, yes and even with the list, the prior booking list, if it's a four week change over, you will find that the NIMS will put in all these names. They will book all these names, prior. But if it comes to the changeover, like next week the people or the names that is there didn't even know, like sister just mentioned, the nurse didn't even receive a message, an sms that she is booked because the agencies, I think they buy, I don't know. They buy people to, I don't know what they get from the department, how much money, what is their rate. If they benefit, actually if they put their member's name on. I don't know that side of the budget of the department. If they, or how do they benefit, if they just block the names from us. Say for instance it is now [redacted] put all their names on and MedX is left with two or three. So who is taking the bulk from the department? The money, from the agency money? So agencies also I have noted has preferences at certain institutions. Neh, it happens. They also get preferences and under cover whatever. So I can rather call now the agency [redacted], it's the closest, but I am not supposed to do that. I have to run through all the four agencies or five that is on tender. But now we just called the first one, ja, which is not supposed to happen. I don't know your story sister that is my life story.
Interviewer	***What is your experience because I can hear the frustration and you've mentioned about the preferences that agencies have, wanting to be associated with certain hospitals, is that what you are saying?***
Participant 2	Yes, that is what I am saying.
Interviewer	***What is your experience?***
Participant 1	My experience, is as I said previously, that because of our geographical area it's a big, big problem because I mean, I can't say now maybe it's the preference of the agency. Because I mean we on NIMS, we select, we don't know who is who, until now the process is done on NIMS, you see. That is the thing. But now that person we have selected probably is saying yes, I will go to [redacted] Hospital probably goes and google [redacted] and False Bay is far away and I don't blame them. So sad for them seven o' clock they still in Fishhoek they must get a taxi to get to the station, because we don't have another mode of transport, the train is the one. And at that time of the night for somebody to, it's not safe in the train, you know. And maybe she is coming this side, like [redacted] or whatever, you know. It's frustrating, it's frustrating, though I mean we thought now it's where we situated. That's why I was so glad to come to this meeting so that I can hear because it seems as if I was not the only one. You know, anyway.
Participant 3	Ja you feel that you're alone.

Appendix 7: Declarations by language and technical editors

Alive! P.T.L. cc

Alive! P.T.L. cc

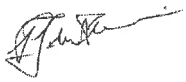
PO Box 1087
Malmesbury 7299

05 December 2019

To whom it may concern

This is to confirm that I, P.L. du Plessis (ID 4812275050080), have read and edited all of the master's thesis *Exploring nurse managers' views on the utilisation of agency nurses in district hospitals in the Cape Metropole* (SELVADOR BRUINERS) as submitted to me for text editing; this to the best of my ability within the time frame.

SIGNED



COO: Philip du Plessis (M.A., S.T.D., B.A. (USA), Certificate for Editing[UCT])

Telephone: 072 880 4993
Email: philipduplessis5@gmail.com

For the people by the people through the people

DATA ANALYSIS TABLE

Theme	Sub-theme	Cluster	Associated quotes
Sourcing of agency nurses	- Rule for sourcing agency nurses	Based on need	...you book your own people the nurses book for that specific area only you don't do it, globally [Khayelitsha FGD P3]. "...you request extra staff which you need. Like for instance for this ward you need a sister or EN" [FG 1, P2, pg. 1]. "...during your planning, you will then uh project for the amount of agency people that you will need" [FG3, P2, pg. 42]. "...we phone them and ask, listen we put this on, uhm we need a nursing assistant or we need, need a sister" [FG4; P1, pg. 59].
		Routine practices	"...when we need the nurse uhm we will phone the agency. Uhm or we will put in on the NIMS system" (FG1, P1, pg.1). "...say for instance you requested a sister, then you gave yourself, say for instance, a hour to get the best available sister. So if you don't get somebody, then you phone the agency" (FG2, P3, pg. 23). "By using NIMS the NIMS request system and also by directly phoning the different agencies" (FG4, P3, pg. 59). "...we would start, obviously, with the pool you have built for yourself...go onto social media...go on your database...sending out adverts...word of mouth... make use of all sorts of telecommunication that you have to your avail...and build the relationship with them (agency nurses)" (AHASA, pg. 85).
	- Using the NIMS systems/Procurement	NIMS compliance	"...you give that agency a request and that request must be a signed off request, an approved request...your managerial processes must be in place. Your administrative process will be the information management (DNS, pg. 79). Like for instance for this ward you need a sister or EN or EN. So, you put it on the system and then it goes to all the, to ten agencies which needs, which have been allocated to work on the system. [FGD 3; P1].

			"...two weeks before the changeover you go into the system... you put it on the syster and then it goes to all the, to ten agencies" (FG1, P2, pg. 1). "Okay we have this system called NIMS, which is Nursing Information Managemen System. This is a system where we have uh electronically requesting nurses on th system" **[FG3, P1, pg. 42]** Also, we use NIMS system to select the staff members, exactly as its happening a Helderberg. Uh, if it is after hours the operational manager can phone an agency direc and also the weekend **FGD P3]**. Yes, we obviously use the Nursing agencies as per the tender process that comes out because that's what were allowed to use, **[FGD 2; P1].**
		Actual implementation of procurement rule/alternative implementation/alt. rule/dual implementation	"It's not just calling a nurse...you give that agency **a request and that request must** b a signed off request, an approved request...the agency clerk can't just call nurses. So you give that agency a request..." (DNS, pg. 78-79). "You are, we, we entering then a fraudulent action because you not supposed t phone and make contact and say who I want" (DNS, pg. 80). Uh, as we say before we uh, in the past, ... they can just phone uh the nursing agencie uh and then that specific nursing agencies will send nurses to their facilities **[IDI P1]** "...there is deviation from the system where we drew verbal or telephonic requests a well." [FG2, P2, pg. 23]. Uhm depending of, on the, the time span when we need the nurse uhm we will phon the agency. Uhm or we will put in on the NIMS system **[g FGD 3; P1].** ja it's the NIMS system or we even phone the nurses, the agency nurses ourselve (FG1, P1, pg. 2).
		Reason/s for alternative implementation/alt. rule/dual implementation	Also, and if people suddenly phone in sick they not coming in well that's ad-hoc its just phone now, because somebody's not coming to work tonight and I was lookin for a RN and ja so I phone directly to an agency who I know will be able to give me on [FG4 P3; pg. 60].